

The Evaluation of the First Year of the Expansion of the Screening Assessment and Support Services (SASS) Program

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I. EXECUTIVE SUMMARY

Commensurate to the initiation of Screening Assessment and Support Services (SASS) for all children and adolescents who are Medicaid eligible, the State of Illinois contracted for an evaluation of this program through Northwestern University's Mental Health Services and Policy Program. Supported by a Memorandum of Understanding, we undertook an evaluation of the SASS program for the fiscal year ending June 30, 2005. The evaluation was a multiple method approach to understand the implementation and impact of the SASS program from multiple perspectives. Among the indicators evaluated were the penetration of SASS services statewide, the utilization of services within episodes of care, the decision-making in regards to referrals to SASS, admission to psychiatric hospitals, the outcomes associated with SASS participation, and the satisfaction for multiple partners with the SASS process.

The evaluation combined utilization data reported by SASS workers, billing data reported to Healthcare and Family Services (HFS) (formerly the Department of Public Aid), and survey data collected from the following partners—parents and other caregivers, SASS program directors and agency directors, hospitals, and other (non-SASS) community behavioral healthcare providers. Decision analysis and outcomes data were collected through the use of the Childhood Severity of Psychiatric Illness (CSPI) which was completed by SASS workers at the initiation of screening and the end of the SASS episode of care. All SASS workers were trained in the reliable use of the CSPI and certified through the use of test case vignettes to ensure the accuracy of these data.

The results of the present evaluation in aggregate demonstrate that the provision of SASS services under The Children’s Mental Health Act of 2003 has been a qualified success. *SASS was able to reach the target population of children and families.* Statewide, services are provided in a timely fashion to more than 15,000 children and adolescents. *SASS decision-making was clinically rational.* The decision-making with regard to the use of psychiatric hospital admissions versus intensive community services is relatively consistent across the state and across demographic groups. More than three quarters of decisions (77%) fit the decision support model. This is an impressive rate for a large public system. There were no large gender, age, or racial disparities in SASS performance, although it does appear the threshold for referral to Crisis and Referral Entry Service (CARES) and SASS is lower for White children and youth than for African Americans. *SASS was effective.* An episode of SASS care is associated with significant clinical and functional improvement, particularly a significant reduction in suicide risk and violence. While overall findings suggest that intensive community services are associated with better outcomes, it was clearly the case that children and youth who fit the decision support criteria for psychiatric hospital admission had better outcomes when hospitalized than when served in the community. Equally important, however, children and youth who did not meet the decision support criteria for hospital admission became worse when hospitalized.

In terms of satisfaction, most partners are satisfied with the CARES line and the process of receiving a SASS referral. In particular, parents and other caregivers report high levels of satisfaction with this service. All partners view SASS as respectful and culturally sensitive. However, some partners are less satisfied with SASS than others. SASS agency directors were not satisfied with the business model and the speed with which they were paid. Hospitals that provide inpatient services for children and adolescents are less satisfied with SASS than hospitals that do not have such expertise. Community behavioral health providers often feel less involved in the service and safety planning processes utilized by SASS than they would prefer. In addition, while the overall decision making and outcomes were good, clear evidence exists of variation across agencies. Therefore, while the use of SASS to serve children and youth through Medicaid has proven to be generally effective, notable opportunities for improving the quality and outcomes of the SASS program exist.

In sum, the totality of the evaluation data suggests that the implementation of the CARES line and the provision of SASS services to all Medicaid eligible children and adolescents has been a qualified success:

- A substantial number of children and adolescents have been served.
- Parents are generally pleased with the services.
- SASS providers feel that they are able to deliver a high quality product
- Other system partners are generally satisfied with SASS.
- Decision-making with regard to the use of intensive community services and psychiatric hospitalization appears to be rational.
- Outcomes are generally good. Intensive community interventions appear to be particularly effective at reducing symptoms and risk behaviors and improving functioning. Outcomes are enhanced by appropriate dispositional decisions.

There do appear to be some areas for improvement. These can be summarized as follows:

- Providers who also serve children and adolescents do not always feel included in the SASS service delivery process.
- There is some variable concern about the professionalism of the CARES line staff and the manner in which they interact with referring individuals.
- SASS providers have some concerns about the viability of the business model and some have struggled to shift to a fee-for-service model.
- Variation across providers in terms of both decision-making and outcomes suggest that the SASS model has not been consistently implemented across the state.

While the evaluation effort this year has utilized data from multiple sources to address the most pressing questions with regard to understanding the impact of SASS on children and families, a number of questions remain unanswered. Among the questions that should be addressed through future evaluation efforts are the following:

- What is the youth perspective on CARES and SASS services?
- What are the differential parent/caregiver perspectives on intensive community services versus psychiatric hospital treatment?
- What is the cut-point at which the clinical benefits of psychiatric hospitalization outweigh those of intensive community interventions? Can that decision-model be communicated to SASS providers and psychiatrists in a way that improves practice?
- Can provider performance be improved through the use of report cards and other feedback and technical assistance strategies?
- Can we better understand racial and cultural factors? Why do African American children and youth present at a higher level of need? Why do Native Americans fair poorly?

The results of the present evaluation indicate that SASS is an effective program with a number of addressable issues identified that, if resolved, could lead it to be an even more effective program. Clearly FY06 priorities should include improving communication and collaboration, ensuring that the business model and the clinical model reinforce each other, and addressing performance variability among providers.

II. BACKGROUND

The extension of the Screening Assessment and Support Services (SASS) program to serve all children and youth covered by Medicaid was an outcome of the Children's Mental Health Act of 2003. In early 2001, a group of advocates and educators pressed for the creation of the Children's Mental Health Task Force. This task force was created in June, 2002. In April of 2003, the task force published its final report: Children's Mental Health: An Urgent Priority for Illinois. Part of the impact of this report was legislation to improve mental health services for all publicly-funded children. The Children's Mental Health Act of 2003 (IL PA 93-0495) was signed into law by Governor Blagojevich in August of 2003.

One of the requirements of the Children's Mental Health Act was for the Department of Healthcare and Family Services (HFS) to implement pre-admission psychiatric hospital screening and assessment procedures for children. This mandate led HFS to partner with the two state code agencies which had already been providing pre-admission screening services to develop a protocol for an expansion of these services to all publicly funded children.

On July 1, 2004, Illinois's Healthcare and Family Services (HFS), working in collaboration with the Departments of Children and Family Services (DCFS) and Human Services (DHS), expanded the availability of the SASS program to all children who were covered by Medicaid or who were deemed presumptively eligible for Medicaid. SASS had previously been operated state-wide as two separate programs, one managed by the Department of Children and Family Services and the other operated by the Department of Human Services through its Division of Mental Health. The expansion required that all SASS providers respond to a Request for Proposal to bid on the provision of these services. In July of 2004, 44 SASS primary contractors began offering services state-wide through this program. Each SASS program is responsible for a specific geography (i.e., area of the state). Some of these providers subcontract with other agencies to provide sufficient geographic coverage of their service areas.

As a component of the expansion of SASS, a central phone intake and referral process was created called the Crisis and Referral Entry Service (CARES). The CARES line takes calls from anyone wishing to refer a child or youth for a SASS assessment. The staff on the CARES line performs a simple screening process to ensure the appropriateness of the referral. If the child or youth meets a defined level of acuity, the CARES staff then refers that individual to the SASS program consistent with the child's geographical location. For all referred children and youth, SASS programs provide both screening and crisis intervention and support services. Thus, SASS workers will perform an assessment to determine whether to provide intensive community services or consider a psychiatric hospital admission. If the child is hospitalized, they provide ongoing monitoring and discharge planning services and help in the child's transition back to the community. If the child is not hospitalized, then SASS provides community stabilization services to ensure that the needs of the child and family are met. The expected duration of SASS services is 90 days; however, SASS programs can request an extension if it is indicated by the clinical circumstances of the case.

The Mental Health Services and Policy Program (MHSP) was selected to perform the first year evaluation of the SASS program primarily because of its nearly decade-long experience evaluating and monitoring the SASS program provided through the auspices of DCFS. In addition, John S. Lyons, Ph.D., the Director of MHSP, is the developer of the Childhood Severity of Psychiatric Illness (CSPI), which is the decision support/outcomes monitoring tool selected to be used within the SASS expansion. In part through the use of the CSPI over a number of years to support clinically driven decisions regarding the use of intensive community support or psychiatric hospital admissions, DCFS was able to reduce and practically eliminate racial disparities in psychiatric hospital admission.

The evaluation process was organized with two levels of collaboration. The evaluation Executive Committee was comprised of Dr. Lyons and Lynn Steiner (Projector Coordinator) from Northwestern University and representatives of the Departments of Healthcare and Family Services (Toni Rozanski), Children and Family Services (Stephanie Hanko and Jane Hastings), and Human Services (Dessie Trohalides). This committee provided direction to the evaluation efforts and facilitated access to information in support of the evaluation.

The Evaluation Advisory Committee includes all members of the Executive Committee and representatives of the various partners affected by the SASS expansion. The membership of this committee includes the following individuals:

Bryan Austin	DCFS Youth Advisory Board
Terry Carmichael	Community Behavioral Healthcare Association
Heather Eagleton-Hemly	Illinois Association of Rehabilitation Facilities
Gaylord Gieseke	Voices for Children, Children's Mental Health Partnership
Scott Leon	Loyola University, Department of Psychology
Kim Miller	Parent Representative
Mark Moses	Ada S. McKinley Community Services, Inc.
Patrick Phelan	Children's Home Association of Illinois
Rita Thorpe	Leyden Family Services
Amy Starin	DHS, Division of Mental Health
Penny Weedon	Robert Young Center
Linda Weiss	Coles County Mental Health Center

The Advisory Committee reviewed all surveys and reports and gave feedback to the evaluator regarding methods, measures, and dissemination strategies.

III. DATA AND METHODS

The evaluation approach was multi-method and involves the convergence of data from multiple sources. Three primary sources were used. Healthcare and Family Services data from the claims database were used to establish baseline data and estimate service use patterns. Claims data has the advantage that SASS programs and hospitals should be highly motivated to submit information consistently to HFS in order to secure payment for services. Claims data has the disadvantage that providers have up to 12 months after the date of service provision in order to submit a claim. Thus the use of claims data to fully evaluate SASS service provision likely underestimates the intensity, frequency and duration of SASS interventions.

The second data source used for the evaluation was screening and assessment data reported by SASS agencies to Northwestern University's Mental Health Services and Policy Program (MHSPP) and used to evaluate decision-making and outcomes. Screening and assessment data has the advantage that it contains information specific to the child and family and allows for a more detailed understanding of the performance of the services. These data have the disadvantage that some SASS providers might be less motivated to submit these data as no clear financial incentives exist for their completion and submission. In addition, clinical assessment information obtained in the field can be notoriously unreliable. To reduce problems of reliability, we insisted that all SASS workers receive training in the use of the assessment instrument and become certified by demonstrating their reliability on a test case vignette. Statewide, 167 SASS workers were certified in the reliable use of the Childhood Severity of Psychiatric Illness (CSPI). Their average reliability was 0.80 which is evidence of very good reliability.

SASS agencies use the CSPI as a decision support and outcomes measure. A copy of the CSPI manual can be found in Appendix A to this report. One of the uses of the CSPI is to model decision-making with regard to psychiatric hospitalization. The basic structure of the CSPI is composed of 27 items and each item has anchored four-point rating scales. However, those anchored definitions are designed to translate into the following four action levels:

- 0 No evidence, no need for action. There is no reason to believe this is a need at this time.
- 1 Watchful waiting, prevention. There is a history of problems or there is suspicion of problems.
- 2 Action. The need is interfering in the child's, family's, or community's functioning and/or wellbeing and it must be addressed.
- 3 Immediate or intensive action. This need is dangerous or disabling.

Based on this measurement model, it is possible to identify which children and adolescents may be in need of a secure psychiatric hospital admission. Specifically, a rating of '3' on one of the following items would indicate an individual who is either acutely dangerous or disabled:

- Neuropsychiatric Disturbance (includes all DSM-IV psychoses)
- Emotional Disturbance (includes all DSM-IV affective disorders)
- Impulsivity (includes ADHD and other disorders of impulse)
- Suicide Risk
- Danger to Others

In addition, since disorders involving psychotic symptoms (e.g., hallucinations, delusions) are less predictable and often difficult to treat or manage, a combination of a '2' on Neuropsychiatric Disturbance and a '2' on either Suicide Risk or Danger to Others would likely warrant consideration of admission to a secure psychiatric hospital admission

Detailed definitions of these items can be found in the CSPI manual in Appendix A. It is important to note that the CSPI is a decision support tool, not an expert system. There certainly are children whose circumstances may necessitate psychiatric hospital admission who do not fit the above decision model. Likewise, there will be children who fit the above criteria but for whom circumstances allow them to be treated in the community with intensive services.

The third data source includes survey results used to assess the multiple perspectives of the various partners in the SASS program. Hospital representatives, SASS program directors and their agency directors, and community mental health providers who do not provide SASS services were surveyed directly. Consistent with HIPAA requirement, parents and caregivers were recruited to

complete surveys by the SASS worker themselves. All data collection, storage, and analyses were compliant with HIPAA guidelines.

IV. UTILIZATION OF SASS SERVICES

The Request for Proposal estimated that about 19,000 SASS screenings would be provided to children and youth. Further, prior hospitalization data estimated that approximately 10,000 children and youth are admitted to a psychiatric hospital each year in Illinois.

In the first year of the SASS program for Medicaid, a total of 15,226 initial screenings were received by Northwestern University. Of these, 9,884 children and youth were admitted into a psychiatric hospital. Thus, since screening signals the beginning of an episode of care in SASS, SASS episodes occurred at about 80% of the expected rate. The total number of hospitalizations is comparable to levels anticipated by historical trends.

Several limitations must be considered in interpreting these basic utilization numbers. First, although we strived to ensure that all SASS workers reported all episodes of service to Northwestern University, it is possible that some episodes went unreported. Some data might have been inadvertently lost during the process of agencies reporting to Northwestern. Thus it is likely that the actual numbers of screenings are at least a little higher than reported. However, there is no reason to believe that substantially more screenings occurred than were reported. Regular monthly reports on the numbers of screenings reported were given to all providers and they had the opportunity to correct any counts that appeared incorrect. Efforts to continue to improve the accuracy of data on the number of episodes of SASS care are underway, including the implementation of a web-based data management system that links SASS data directly to eligibility data collected by HFS and CARES.

The same logic holds for hospital admission, although it is likely that SASS programs reported on most cases in which a hospitalization occurred (due to the high profile of these cases for the SASS workers and programs), reducing the size of any potential underestimate of hospital admissions. In other words, we believed that missed episodes of care mostly involved short-term interventions in the community (i.e., the lowest profile cases for SASS workers and programs). The comparison of hospital admissions based on HFS claims data to that based on SASS program reports to Northwestern is

potentially problematic due to the differences in methods. Since hospitals still have a considerable amount of time to bill for care provided in the past fiscal year, accurate billing data is not yet available for the first year of the SASS program for Medicaid.

Table 1 presents screenings by region. Not surprisingly, Cook County saw the greatest number of SASS screenings with slightly more than 7,000 and Southern saw the fewest with slightly more than 1,000.

Table 1. FY05 SASS Utilization by Region, for Screens Performed 07/01/04 through 6/30/05.

Region	Total	Community Stabilization	%	Psychiatric Hospitalization	%
Statewide	15,226	5,342	35.1%	9,884	64.9%
Cook County	7,047	1,980	28.1%	5,067	71.9%
Central	4,414	1,944	44.0%	2,470	56.0%
Northern	2,586	965	37.3%	1,621	62.7%
Southern	1,179	453	38.4%	726	61.6%

Figure 1 presents the rate of hospital admissions for all screenings by month. While the rate of hospital admissions peaked at the start of the fiscal year and was lower for the rest of the year, there was an increase during the last month of the fiscal year. This figure suggests that while SASS workers appear to improve the likelihood of utilizing intensive community interventions after the first two months, there may be a trend over time to return back towards the initial baseline rate of hospitalizing about two-thirds of all screenings.

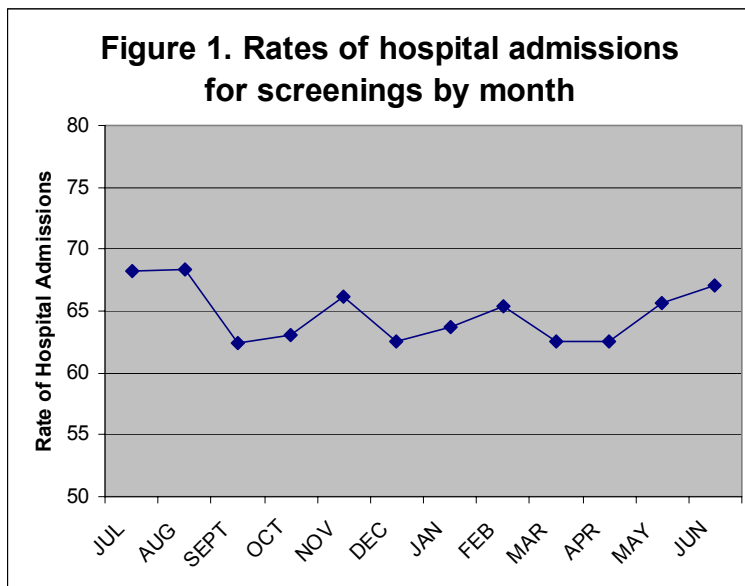


Table 2 presents the distribution of screenings and psychiatric hospital admissions broken out by gender, age, and race. There are about 600 fewer screenings represented in this table because gender, age, and race were sometimes missing from reports submitted by SASS workers. Missing data were not included. There were slightly more boys served than girls overall. In addition, boys tended to be assessed as having high-risk symptoms and behaviors. There did not appear to be any differences in rates of hospitalization between boys and girls. About two-thirds of all SASS referrals were followed by a psychiatric hospital admission.

The majority of SASS screenings involved adolescents. Only a small percentage of referrals to SASS were for children under five years old (2%). The most common ages were 13 to 15 years old (38%). However, about one quarter (27%) of all SASS referrals were for children ages six to 12. The likelihood of psychiatric hospital admission increased with age, from 56% for children five and under to 68% of youth 16 years or older. This finding is consistent with other findings that adolescents are generally more difficult to control than children and thus sometimes require more intensive levels of care.

White children (49%) were the most common racial group served, although a substantial percentage of children were African American (39%). There was a tendency for African American children to be hospitalized more frequently than White children; however, this appears to be the result of African American children being assessed as having higher risk symptoms and behaviors at SASS screening. Thus, while there was a racial disparity in hospitalization rates it may reflect an actual racial disparity in the threshold for referring children and youth to SASS services rather than a hospital admission threshold difference. In other words, it appears that African American children and youth are seen at a point when they present with more symptoms and higher levels of risk behaviors than do White children. This suggests challenges in the process of detection and referral from the community to SASS rather than a problem with how CARES or SASS serves African American children and youth. More discussion on evaluating racial disparities in psychiatric hospital admissions can be found in the Section V. Decision Analysis.

Table 2. FY05 SASS Utilization by Gender, Age and Race, for Screens Performed 07/01/04 through 06/30/05.

	Total	%	Community Stabilization	%	Psychiatric Hospitalization	%
GENDER						

Male	7364	51%	2617	36%	4747	64%
Female	7063	49%	2498	35%	4565	65%
AGE						
< 5	325	2%	142	44%	183	56%
6 – 12	3877	27%	1484	38%	2393	62%
13-15	5591	38%	2004	36%	3587	64%
16 >	4622	32%	1480	32%	3142	68%
RACE						
Black	5483	39%	1812	33%	3671	67%
Hispanic	1288	9%	410	32%	878	68%
Asian/Oriental	43	<1%	15	35%	28	65%
White	6903	49%	2618	38%	4285	62%
American Indian/Eskimo	18	<1%	5	28%	13	72%
Other	471	3%	177	38%	294	62%

Table 3 presents screening by participating SASS agencies. In addition, by each agency name there is an indicator of whether or not its LAN contains psychiatric hospital beds for adults and for children and adolescents. This is an important indicator in that it is generally easier to obtain a psychiatric hospital admission if the hospital serves the geographic area in which the child and family live. In addition, parental and caregiver involvement during the hospital stay is easier when the hospital is closer to home. Also, many children and families appear at emergency rooms when in crisis, so the potential for providing community stabilization services decreases when the child and family have already presented at a hospital setting. The role of hospital availability on admission rates both in terms of location and bed availability requires further study.

Subcontracting agencies are reported under the agency that holds the contract with the State of Illinois. In this table, substantial variation can be seen across the 55 agencies which contract and subcontract to provide SASS services. One Cook County provider served more than 1,000 children and adolescents through fiscal year 2005 (FY05); of these, 66.9% were hospitalized. In contrast, five agencies served ten or fewer children. Of the 35 children served by these five agencies, 14 (40%) were hospitalized.

Table 3. FY05 SASS Utilization by Provider, for Screens Performed 07/01/04 through 06/30/05.

Type of Hospital in LAN	Sub-Contracted SASS provider	Screening provider	Screenings reported**				
			N	<u>Served in Community</u>		<u>Hospitalized</u>	
				Total	High risk* children and adolescents	Total	Low risk* children and adolescents

Adult	C & A				N	%	N	%	N	%	N	%
			Total screens	15,226	5,342	35.1	1,546	28.9	9,884	64.9	2,256	22.8
X			Ada S. McKinley Community Services, Inc.	667	278	41.7	47	16.9	389	58.3	59	15.2
			Ben Gordon Center	62	17	27.4	4	23.5	45	72.6	8	17.8
			Bridgeway	218	137	62.8	34	24.8	81	37.2	12	14.8
X			Catholic Charities Diocese	150	95	63.3	32	33.7	55	36.7	19	34.5
			Center for Children's Services (Starting 1/1/05)	97	67	69.1	31	46.3	30	30.9	3	10.0
X	X		Children's Home Association of Illinois	718	288	40.1	71	24.7	430	59.9	90	20.9
X			Coles County Mental Health Association, Inc.	277	146	52.7	59	40.4	131	47.3	22	16.8
			Community Care Options	923	232	25.1	25	10.8	691	74.9	200	28.9
X	X		Community Counseling Center of Chicago	1,085	359	33.1	56	15.6	726	66.9	229	31.5
X	X		Community Counseling Ctr. of Northern Madison County	235	48	20.4	9	18.8	187	79.6	90	48.1
			Community Mental Health Council	320	80	25.0	19	23.8	240	75.0	40	16.7
			Community Resource Center	66	26	39.4	5	19.2	40	60.6	8	20.0
X			Comprehensive Mental Health Center	66	21	31.8	5	23.8	45	68.2	11	24.4
X	X		Crosspoint Human Services	788	333	42.3	110	33.0	455	57.7	50	11.0
X	X		DuPage County Health Department	542	172	31.7	69	40.1	370	68.3	121	32.7

*Level of risk determined by severity on CSPI items predictive of hospitalization versus service in the community.

**Data from incomplete CSPIs are not included.

Table 3 Continued

Adult C & A		Type of Hospital in LAN	Sub-Contracted SASS provider	Screenings reported**									
				Screening provider	N	Served in Community				Hospitalized			
						Total		High risk* children and adolescents		Total		Low risk* children and adolescents	
				N	N	%	N	%	N	%	N	%	
				Total screens	15,226	5,342	35.1	1,546	28.9	9,884	64.9	2,256	22.8
X				Egyptian Public and Mental Health Department	87	30	34.5	15	50.0	57	65.5	7	12.3
				Familv Counseling Center, Inc.	129	73	56.6	21	28.8	56	43.4	9	16.1

X	X		Family Service Association of Greater Elgin Area	550	209	38.0	44	21.1	341	62.0	70	20.5
			Franklin-Williamson Human Service, Inc.	96	27	28.1	12	44.4	69	71.9	10	14.5
X	X		Grand Prairie Services	697	169	24.2	28	16.6	528	75.8	151	28.6
X			Heartland Human Services	41	13	31.7	3	23.1	28	68.3	7	25.0
X	X		Helen Wheeler Center for Community Mental Health	317	149	47.0	59	39.6	168	53.0	30	17.9
X	X		Heritage Behavioral Health Center, Inc.	447	191	42.7	57	29.8	256	57.3	80	31.3
		X	--DeWitt County Human Resource Center	13	8	61.5	4	50.0	5	38.5	0	0.0
		X	--Piatt County Mental Health Center	3	0	0.0	0	0.0	3	100.0	1	33.3
			Kids Hope United	271	109	40.2	36	33.0	162	59.8	32	19.8
			Human Service Center	14	5	35.7	2	40.0	9	64.3	2	22.2
			Human Support Services	9	3	33.3	2	66.7	6	66.7	1	16.7
			Institute for Human Resources	55	38	69.1	13	34.2	17	30.9	1	5.9
			Jane Addams Family Counseling Ctr of Stephenson Cty	93	40	43.0	16	40.0	53	57.0	9	17.0
X	X		Janet Wattles Center, Inc.	499	198	39.7	99	50.0	301	60.3	47	15.6
X	X		Jewish Children's Bureau	49	22	44.9	7	31.8	27	55.1	11	40.7
			Kenneth W. Young Centers	1,104	254	23.0	63	24.8	850	77.0	148	17.4
X	X		Lake County Health Department and Community Health	421	158	37.5	71	44.9	263	62.5	30	11.4

*Level of risk determined by severity on CSPI items predictive of hospitalization versus service in the community.

**Data from incomplete CSPIs are not included.

Table 3 Continued

Type of Hospital in LAN Adult C & A		Sub-Contracted SASS provider	Screening provider	Screenings reported**								
				N	Served in Community				Hospitalized			
					Total		High risk* children and adolescents		Total		Low risk* children and adolescents	
			N	N	%	N	%	N	%	N	%	
			Total screens	15,226	5,342	35.1	1,546	28.9	9,884	64.9	2,256	22.8
X	X		Leyden Family Service and Mental Health Center	812	97	11.9	19	19.6	715	88.1	169	23.6
			McHenry County Mental Health Board	251	87	34.7	29	33.3	164	65.3	24	14.6
			McLean County Center for Human Services	5	3	60.0	0	0.0	2	40.0	1	50.0
X	X		Mental Health Centers of Central Illinois	460	206	44.8	56	27.2	254	55.2	72	28.3
		X	--Christian County Mental Health	18	5	27.8	1	20.0	13	72.2	2	15.4

		X	--Logan County Health Department	19	10	52.6	8	80.0	9	47.4	1	11.1
X	X		Metropolitan Family Services	410	152	37.1	42	27.6	258	62.9	58	22.5
X			Mount Sinai Hospital	178	26	14.6	9	34.6	152	85.4	31	20.4
		X	--Mujeres Latinas en Accion	120	6	5.0	1	16.7	114	95.0	19	16.7
X	X		North Central Behavioral Health Systems	283	50	17.7	17	34.0	233	82.3	58	24.9
			Provena Behavioral Health (Ending 12/31/04)	96	50	52.1	15	30.0	46	47.9	6	13.0
X	X		Robert Young Center	421	201	47.7	55	27.4	220	52.3	49	22.3
			Schuyler County Mental Health Services	18	9	50.0	2	22.2	9	50.0	3	33.3
		X	--Cass County MHC	8	3	37.5	2	66.7	5	62.5	0	0.0
		X	--Morgan Scott Mental Health	10	5	50.0	1	20.0	5	50.0	2	40.0
X			Sinnissippi Centers, Inc.	166	84	50.6	67	79.8	82	49.4	8	9.8
			Southeastern Illinois Counseling Centers, Inc.	88	46	52.3	27	58.7	42	47.7	7	16.7
			Southern Illinois Regional Social Services	86	55	64.0	14	25.5	31	36.0	10	32.3
X	X		Transitions of Western Illinois	229	47	20.5	15	31.9	182	79.5	65	35.7

*Level of risk determined by severity on CSPI items predictive of hospitalization versus service in the community.

**Data from incomplete CSPIs are not included.

In addition to service utilization, the timeliness of the response by CARES and SASS was evaluated by the DHS/DMH Child and Adolescent Statewide Service System in March and April of 2005. A sample of 500 CARES calls were analyzed for efficiency of referrals to SASS. The time between the initial referral to CARES and the CARES call to SASS was, on average, 16.7 minutes: 48% occurred within 10 minutes, 35% occurred within 11 to 20 minutes, 10% occurred between 21 and 30 minutes, 4% occurred between 30 and 60 minutes, and 3% took more than 60 minutes to complete. Thus, 93% of all CARES calls resulted in a SASS referral within 30 minutes or less. These findings are well within the guidelines of the RFP.

The time interval between the referral to SASS and the SASS response was similarly assessed. The average response time was 8.1 minutes: 75% occurred within 10 minutes, 16% occurred in 11 to 20 minutes, 5% occurred in 21 to 30 minutes, 3% occurred between 31 and 60 minutes, and 1% required more than 60 minutes. Thus, 96% of all SASS responses occurred within 30 minutes of the CARES referral to SASS.

Service Use

The only available source of services utilized within the SASS program is the claims data collected by HFS. In the claims data, services are divided into on-site and off-site services. For FY05 as of 7/12/05, a total of 178,703 on-site units of service were billed and a total of 347,734 off-site units of service were billed. Given the 12-month window from time of service to billing, this amount can be expected to increase. The ratio of on-site to off-site services was 0.66.

While the goals of the present evaluation do not include a detailed analysis of service use nor do we currently have the capacity to tie individual service use back to outcomes, it is instructive for the purposes of the present evaluation to inventory the general distribution of the most commonly billed services.

Service Category	On-site Units	%	Off-site Units	%
Case Management	71,976	40%	67,497	19%

Therapy/counseling	41,538	23%	126,857	36%
Assessment	24,392	14%	41,211	12%
Crisis Intervention, including pre-screening	17,657	10%	73,416	21%
Treatment Planning	7,785	4%	19,623	5%
Behavioral services	6,692	4%	32,641	9%
Psychotropic Meds	3,713	2%	280	>1%
Skill Training	828	>1%	249	>1%
Activity Therapy	325	>1%	590	>1%

V. DECISION ANALYSIS

A. CARES DECISION ANALYSIS

In order to better understand the role of CARES in referring children and adolescents to SASS, a random sample of 203 CARES referrals were taken and evaluated compared to the CSPIs completed by SASS at the initial screening following referral. The distribution of the responses to the CARES screening items were as follows:

	%Yes	%No
Has youth made statements involving wishes to harm self*	35.0	65.0
Has youth described specific plan for harming self*	10.8	89.2
Does youth have access to means to carry out plan of self-harm*	5.9	94.1
Has youth made prior attempts to harm self*	24.6	75.4
Has youth made deliberate attempts to harm self*	20.7	79.3
Has youth severely harmed someone*	22.7	77.3
Is youth dangerously out of control*	45.8	54.2
Is youth displaying bizarre behavior*	10.8	89.2
Is youth killing, maiming or torturing animals	2.0	98.0
Is youth essentially presenting oppositional or undesirable behavior	14.8	85.2
Is youth displaying aggressive sexual behavior	1.0	99.0
Is youth primarily involved in delinquent behavior	7.4	92.6
Does youth have prior psychiatric hospitalizations	52.7	47.3
Is psychotropic medication currently being prescribed	56.2	43.8
If yes, is the youth non-compliant with medication	22.7	77.3

*These items reflect symptoms that might inform psychiatric hospital admission decisions.

Review of these responses indicated that a prior history of psychiatric hospitalization and current psychotropic medication along with ‘out of control’ behavior are the more common screening factors for SASS referrals. Statements and actions regarding self harm are common. Violence against others is also common.

In 62 of 69 cases (90%) SASS workers agreed with the CARES acuity screen that an indication of a youth's wishes for self-harm was present. This detection rate was even higher for youth who had a specific plan according to the CARES acuity screen (95%). SASS workers observed acute Suicide Risk in only 11 of 128 cases that did not meet this CARES screen item. This is not surprising given that SASS uses a face-to-face interview with the child or youth for an assessment which is more likely to elicit direct information on suicidal ideation. Thus, the sensitivity of the wishes to harm self item on the CARES acuity screen was estimated at 0.90 with a specificity of 0.91. In other words, the CARES acuity scale appears to do a good job of identifying cases in need of intervention (i.e., sensitivity) without over-identifying a large number of cases that do not require intervention (i.e., specificity) on this dimension.

For Danger to Others, the SASS worker agreed on 43 of 46 cases in which the CARES referral indicated that the youth had severely harmed another and that danger to others was present (93.4%). However, SASS workers observed acute Danger to Others on 21 of 150 cases that did not meet this screening standard (14%). Thus this item's sensitivity was 0.93 and specificity was 0.86.

B. SASS DECISION ANALYSIS

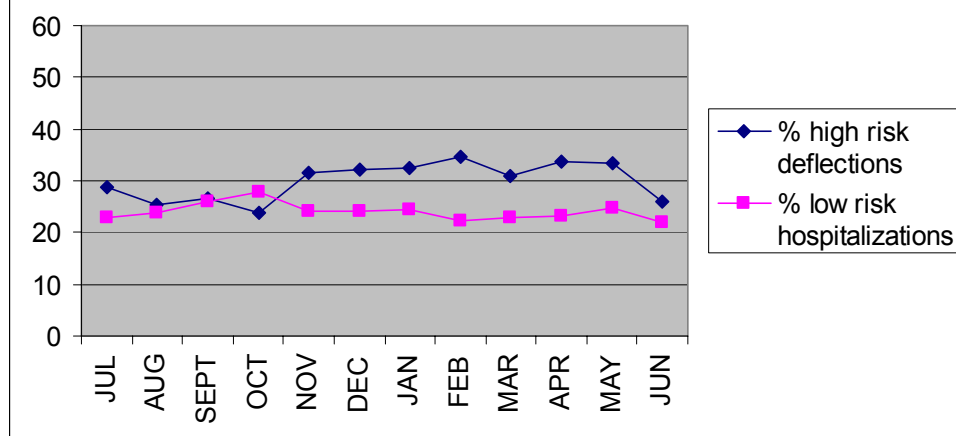
As seen in Table 1, across the state 23% of all hospital admissions would be characterized as low risk. This means that 77% of all hospital admissions fit the above decision model. This is actually quite impressive. In a tightly managed private emergency room setting, the highest expected rate of high-risk admissions is not more than 85% to 90%. So, a state-wide rate in a Medicaid population of 77% is quite good for the first year of this initiative. When SASS served only DCFS children, initially 66% of cases fit the decision model. It appears that the experiences of the SASS program prior to this past year may have informed its success in matching children to community- versus hospital-based services.

There was some variation in low-risk admissions by region. Interestingly, the most low-risk hospital admissions were in Southern and Cook. Northern had the lowest percentage of low-risk admissions.

The rate of high-risk community stabilizations was 29%. Northern had the highest percent of high-risk community stabilizations. These two findings suggest that the Northern region either has the least access to psychiatric hospital services or the greatest ability to effectively provide intensive community-based services. The fact that one of the largest agencies in the region in terms of SASS screenings has access to both adult and child and adolescent beds in its Local Area Network (LAN) may suggest that the region is strong on intensive community services. However, more analyses regarding provider performance and the sustainability of the SASS intervention are required to fully address this question.

Figure 2 provides the monthly rate of low risk admissions and high-risk community stabilization. Review of these data suggests that over the course of the year, there was a gentle trend for SASS programs to serve increasingly challenging youth with intensive community services rather than psychiatric hospitalization. The probability of hospitalizing a 'low-risk' child or adolescent remain relatively stable although there was a slight trend for fewer low-risk admission over the course of the year. The percent of high-risk community stabilizations generally increased over the course of the fiscal year.

Figure 2. Rates of low risk admissions and high risk deflections by month



Referring back to Table 3, all agencies are profiled based on the rate of ‘low-risk admissions’ and ‘high-risk deflections.’ Although, for the most part, the decision-making with regard to psychiatric hospital admissions versus intensive community services appears consistent across the state, there is observable variation in decision-making across agencies. Of agencies serving at least 100 children and adolescents, the highest rate of low-risk admissions was 48% while the lowest rate was 10%.

As mentioned above, for the agency with the highest rate of high-risk community stabilization cases for those serving more than 100 children and adolescents, half of the children and adolescents served in the community had symptoms and risk behaviors consistent with psychiatric hospital admissions. This finding suggests that this agency may have one of the more sophisticated community interventions or less access to psychiatric hospital services. The agency that had only a 1.6% rate of high-risk children and youth served with community stabilization suggests that this agency was not comfortable serving high-risk children and adolescents with intensive community services. In order to fully understand the implications of these data, it will be necessary to evaluate each agency’s rate of representation and functional improvement.

To better understand the role of symptom, risk and caregiver characteristics in the use of psychiatric hospitalizations, all CSPI ratings at the initial screening were entered into a logistic regression model predicting whether or not the child or youth was hospitalized at any point during the SASS episode of care. Table 4 presents the CSPI items that were significant predictors of hospital admission. Overall, 78% of cases were accurately classified, which is statistically significant.

Table 4. Individual items of the Childhood Severity of Psychiatric Illness (CSPI) provided at the original screening that significantly predict a psychiatric hospitalization at any time during the SASS episode of care.

CSPI Item	B	S.E.	Wald	p	Implications
Suicide Risk	0.72	0.05	205.36	.000	Greater suicide risk is associated with increase risk of admission
Danger to Others	0.62	0.06	113.73	.000	Greater danger to others is associated with increased risk of

Neuropsychiatric Disturbance	0.37	0.65	31.75	.000	admission Psychotic symptoms are associated with increased risk of admission
Emotional Disturbance	0.37	0.65	31.45	.000	Higher levels of depression and anxiety are associated with increased risk of admission
Impulsivity	0.30	0.61	24.36	.000	Symptoms of impulse control problems are associated with increased risk of admission
Elopement	0.23	0.05	19.42	.000	Running away is associated with increased risk of admission
Unavailability of Services	0.29	0.09	9.36	.002	Available community services is associated with lower risk of admission
Family Functioning	0.17	0.06	8.44	.004	Family problems are associated with increased risk of admission
Adjustment to Trauma	-0.09	0.05	3.87	.049	Trauma experiences are associated with a decreased risk of admission
Caregiver Lack of Knowledge	-0.19	0.09	4.85	.028	Knowledgeable caregivers' children are more likely to be admitted to hospital
Multi-system involvement	-0.17	.007	5.56	.018	Children involved in multiple systems are less likely to be admitted

Note: To interpret this table, one needs to study the regression weights (B). S.E. is the standard error of these regression weights. The 'Wald' statistic is the standard logistic regression test of whether the regression weight is different from zero (i.e. there is a statistically significant relationship between the CSPI items and the decision to treat in the community).

All these weights are statistically significant (i.e., different) from zero indicating that the CSPI items have a statistically significant relationship to the hospitalization versus intensive community intervention decision. A positive B indicates that higher ratings on the CSPI item are related to an increased likelihood of hospital admission. A negative B indicates that higher the rating on the CSPI item is related to an increased likelihood of an intensive community intervention. In general, the more symptomatic the child, the greater the likelihood of hospital admission. Similarly the greater the propensity towards high risk behavior, the greater the likelihood of hospital admission. These findings are exactly as they should be in a well-functioning crisis assessment and triage program. Several items had negative B. Thus, children and youth with recognized trauma problems, including Post Traumatic Stress Disorder (PTSD), were more likely to be served in the community. Youth with caregivers who were seen as knowledgeable, were more likely to be admitted into the hospital. This finding may seem counter-intuitive; however, it replicates findings elsewhere. It appears that when a SASS worker has concerns about the caregiver's knowledge, the intervention is more likely to include a direct educational intervention with the caregiver and reduce the need for hospitalization. A crisis circumstance with a knowledgeable caregiver is often involves concerns about the safety of the child. Finally, youth with complex multi-system involvements (e.g. DCFS, juvenile court) were more likely to be served in the community. These findings also are consistent with sound clinical decision-making in the SASS program.

VI. OUTCOMES

There are a variety of ways in which the CSPI can be used as an outcome monitoring tool. The standard method is to sum the items within domains (e.g. symptoms, risk behaviors, functioning) and study change over time on these scale scores. Table 5 presents the overall analysis of change for all children and adolescents for whom both a completed CSPI at screening and at termination of the SASS episode of care were submitted to Northwestern University during last fiscal year. As can be seen from this Table, SASS involvement was associated with significant improvement overall of approximately 4 (15.0 to 10.6), of nearly 2 on symptoms (6.8 to 5.0), and 2 on risk behaviors (3.8 to 2.1) and of 1 on functioning (4.3 to 3.5). All of these improvements were statistically significant and clinically meaningful. Careful review of these tables indicates a substantial amount of missing data for these analyses. This is primarily due to three causes. First, SASS workers were not required to submit a second CSPI if they only saw the child one time. Second, open cases at the end of the fiscal year did not include a final CSPI. Finally, some SASS workers failed to submit CSPI data on their closed cases.

Table 5. FY05 SASS Outcomes by Provider, from Terminate CSPIs Received 07/01/04 through 06/30/05.

SASS Provider	# Clients with Screening & Terminate CSPIs qualifyin	Mean CSPI Symptoms (max=15)*	Mean CSPI Risk Behaviors (max=15)*	Mean CSPI Functioning (Max=9)*	Mean Total= Symp+Risk+Funct (max=39)*
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	g for this report**								
		Initial Screenin g+	Terminati on	Initial Screenin g+	Terminati on	Initial Screenin g+	Terminati on	Initial Screening+	Terminati on
Total	2887	6.83	5.00	3.84	2.10	4.28	3.45	14.95	10.55
Ada S. McKinley C.S.Inc.	244	7.15	6.77	3.74	3.30	4.65	4.51	15.54	14.58
Ben Gordon Ctr	26	6.77	6.50	4.19	3.73	3.81	3.58	14.77	13.81
Bridgeway	20	6.45	4.35	3.05	1.60	3.60	2.90	13.10	8.85
Catholic Charities	19	5.74	4.47	2.79	1.63	3.32	2.95	11.84	9.05
Ctr for Children's Svs	24	6.04	4.54	4.17	2.29	3.50	2.88	13.71	9.71
CHAIL	116	6.75	5.47	3.59	1.63	4.42	3.94	14.76	11.03
Coles County MHA, Inc.	48	6.44	4.29	3.35	2.08	3.17	3.50	12.96	9.88
Community Care Options	139	7.60	5.00	3.99	1.48	4.61	3.86	16.21	10.35
Community Counseling Ctr/ Chgo	210	6.22	4.92	3.35	2.00	4.44	3.93	14.01	10.86
Comm Couns Ctr/ N Madison Cty	3	3.33	3.00	2.67	2.33	3.67	3.00	9.67	8.33
Comm MH Council	26	6.81	4.23	3.58	2.04	3.81	2.27	14.19	8.54
Comm Resource Ctr									
Heartland Human Svs									
Crosspoint Human Svs	60	7.12	6.48	3.70	2.42	4.03	3.90	14.85	12.80

^ Received by NU between 7/1/04 and 6/30/05

* Higher CSPI scores indicate greater severity

** Only includes clients w/ initial screening CSPI completed

+ Refers to initial screening for "episode" of SASS services ending in termination of interest. "Episode" must be between 3-120 days

Table 5 Continued

SASS Provider	# Clients with Screeni ng & Termin ate CSPIs qualifi ng for this report**	Mean CSPI Symptoms (max=15)*		Mean CSPI Risk Behaviors (max=15)*		Mean CSPI Functioning (Max=9)*		Mean Total= Symp+Risk+Func (max=39)*	
		Initial Screenin g+	Terminati on	Initial Screenin g+	Terminati on	Initial Screenin g+	Terminati on	Initial Screening+	Terminati on
Total	2887	6.83	5.00	3.84	2.10	4.28	3.45	14.95	10.55
DuPage County HD	73	6.51	4.71	4.12	2.12	4.22	3.30	14.85	10.14
Egyptian Public & MHD	35	7.29	5.29	4.74	1.80	4.80	3.83	16.83	10.91
Family Counseling Ctr	26	5.27	4.46	3.08	1.42	2.69	2.38	11.04	8.27
Family Service Association/ Greater Elgin Area	150	5.92	5.26	3.19	2.38	3.59	3.57	12.69	11.21
Franklin-Williamson HS	11	8.73	6.36	4.09	3.27	5.09	4.73	17.91	14.36
Grand Prairie Services	119	7.07	3.74	3.82	1.38	4.25	2.65	15.14	7.76
Helen Wheeler Center	25	7.00	5.92	3.44	2.80	4.44	3.76	14.88	12.48
Heritage BHC	49	6.27	4.45	3.90	1.63	3.94	2.63	14.10	8.71
DeWitt County HR Ctr									
Piatt County MHC									
Human Service Center	2	9.00	6.50	6.00	3.50	7.50	5.50	22.50	15.50
Human Support Svs									
Institute for Human Res.									
Jane Addams	26	7.73	4.85	4.38	1.77	5.00	3.46	17.12	10.08
Janet Wattles Center	79	6.16	4.85	4.72	2.39	3.77	3.23	14.66	10.47
Jewish Children's Bureau	20	5.80	4.30	2.90	1.70	3.55	3.05	12.25	9.05
Kenneth W. Young Centers	330	7.07	5.36	4.28	2.15	4.66	3.99	16.01	11.50
Kids Hope United	44	5.61	4.23	3.84	2.30	3.20	2.75	12.66	9.27
Lake County Health Department	106	6.95	5.84	4.58	3.24	4.48	4.01	16.02	13.08
Leyden Family Service	43	8.00	5.05	4.44	2.07	4.53	3.56	16.98	10.67
Lutheran Social Service of IL	67	6.04	3.49	3.57	1.15	4.30	2.28	13.91	6.93
Macoupin County Community Mental Health	123	5.06	3.56	3.37	1.53	3.25	2.50	11.67	7.59
McHenry County Mental Health Board	37	6.97	5.59	3.97	2.59	4.68	3.76	15.62	11.95
McLean County Center for Human Services									

Mental Health Centers of Central Illinois	116	6.77	5.85	3.43	2.34	4.05	3.72	14.25	11.92
Christian County MH	2	12.00	6.50	4.00	0.00	7.50	7.00	23.50	13.50
Logan County Health Dept	9	6.44	2.67	3.11	0.56	3.33	1.56	12.89	4.78
Metropolitan Family Services	37	6.46	4.92	3.38	2.11	3.19	2.76	13.03	9.78
Mount Sinai Hospital	14	6.64	2.43	3.64	0.57	4.71	2.36	15.00	5.36
Mujeres Latinas en Accion	13	8.23	7.77	4.85	2.77	5.23	5.15	18.31	15.69
North Central Behavioral Health Systems	74	6.27	5.55	3.61	2.58	3.80	3.55	13.68	11.69
Robert Young Center	58	9.02	6.28	4.19	3.28	5.02	3.97	18.22	13.52
Schuyler County Mental Health Services	5	7.20	3.80	4.80	2.20	4.40	3.00	16.40	9.00
Cass County MHC	7	7.14	5.29	4.86	3.57	5.14	2.14	17.14	11.00
Morgan Scott Mental Health	14	6.71	4.21	3.50	1.50	4.64	2.21	14.86	7.93
Sinissippi Centers, Inc.	59	7.61	6.22	4.80	2.80	4.88	4.10	17.29	13.12
Southeastern Illinois Counseling Centers, Inc.	34	7.26	6.18	4.06	2.21	4.41	5.29	15.74	13.68
Southern Illinois Regional Social Services	34	5.24	4.50	3.03	2.29	3.15	3.18	11.41	9.97
Transitions of Western Illinois	99	6.28	4.72	3.78	1.78	3.52	3.14	13.58	9.64

[^] Received by NU between 7/1/04 and 6/30/05

* Higher CSPI scores indicate greater severity

** Only includes clients w/ initial screening CSPI completed

+ Refers to initial screening for "episode" of SASS services ending in termination of interest. "Episode" must be between 3-120 days

Overall, there were no regional differences in outcomes, with all regions reporting an approximate four point improvement on the CSPI total. This change represents a substantial and clinically meaningful improvement. Similar patterns were observed for each of the scale scores. Thus, in general, outcomes were consistent across the state.

Boys tended to both enter and exit SASS services with higher assessed needs. Boys initiated SASS services 1.4 points higher than girls and terminated 1.1 points higher. Because they started with higher needs, boys benefited slightly more from SASS services than girls. This difference was statistically significant.

There do not appear to be racial disparities in overall outcomes. There were racial differences in severity of need at screening, with African American children and adolescents having the highest need and Asian children and adolescents having the lowest need. However, all racial groups had comparable improvements on average of about four points. The notable exception was the small number of Native American/Eskimo youth served. These six youth had a very high initial level and did not appear to benefit from SASS services.

While all age groups appeared to benefit from SASS services, children 12 and under appear to benefit somewhat more from SASS services than do adolescents 13 and older. Children had an improvement of more than four points while adolescents improved only 3.5 points on average. This difference is statistically significant.

A second means of using the CSPI is for an item level analysis to understand which needs move from 'actionable' levels to no longer being needs or prevention of relapse. In other words, by determining the numbers of children and youth who are rated as a '2' or '3' on each item who then are rated as a '0' or '1' at termination, it is possible to identify which individuals' needs are addressed by SASS for what percentage of individuals. Table 6 presents each of the individual items in terms of the percentage of children and youth with each of the four levels of severity at initiation and termination of SASS involvement. In order to interpret these data, one should compare the percentages of '3' and '2' ratings in the 'Initial Screening' section to those ratings in the 'Termination' column. For example, at Initial Screening 4% of children and youth have a '3' rating on Neuropsychiatric Disturbance indicating a dangerous or disabling level of psychosis. Only 1% of children and youth have this level of need at termination from SASS services. For Emotional Disturbance, the percentage of '3' ratings, which translates into a dangerous or disabling level of depression or anxiety, falls from 18% to 6%.

Table 6. Percentage of children and youth rated at each of four levels of severity of need on the Childhood Severity of Psychiatric Illness (CSPI) at Initial Screening and Termination of SASS involvement

CSPI Item	INITIAL SCREEN	TERM SCREEN	INITIAL SCREEN	TERM SCREEN	INITIAL SCREEN	TERM SCREEN	INITIAL SCREEN	TERM SCREEN
Rating	0	0	1	1	2	2	3	3
NEUROPSYCHIATRIC DISTURBANCE	67	69	19	23	10	7	4	1
EMOTIONAL DISTURBANCE	5	8	28	47	50	40	18	6
CONDUCT	30	36	36	43	22	17	12	4
OPPOSITIONAL BEHAVIOR	16	18	35	48	34	28	15	6
IMPULSIVITY	9	15	28	48	40	30	22	7
SUICIDE RISK	36	55	25	39	23	5	16	2
DANGER TO OTHERS	32	49	30	41	24	9	14	2
ELOPEMENT	52	63	23	25	15	9	10	4
CRIME/ DELINQUENCY	70	72	17	17	9	8	5	3
SEXUAL AGGRESSION	90	92	6	6	3	2	1	1
SCHOOL FUNCTIONING	20	23	33	42	31	24	16	11
FAMILY FUNCTIONING	14	14	34	45	35	32	17	10
PEER FUNCTIONING	26	29	35	44	29	21	10	5
ADJUSTMENT TO TRAUMA	44	46	22	31	23	19	11	5
MEDICAL CO-MORBIDITIES	79	81	13	13	7	5	1	1
SUBSTANCE ABUSE	76	74	15	18	7	6	3	2
ABUSE HISTORY	58	59	19	23	14	12	9	6
SEXUAL DEVELOPMENT	84	84	9	11	4	3	3	2
LEARNING PROBLEMS	67	69	18	19	11	9	4	4
CAREGIVER SUPERVISION	53	57	32	33	12	9	3	2
CAREGIVER MOTIVATION	63	62	25	27	9	9	3	2
CAREGIVER KNOWLEDGE	58	62	30	30	9	7	3	1
SAFETY	72	77	20	19	6	3	2	1
AVAILABILITY OF SERVICES	76	82	17	14	5	3	1	1
MULTISYSTEM INVOLVEMENT	60	64	26	26	12	9	2	1

Review of the data presented in Table 6 suggests that much of the improvement observed in Table 5 comes from children and adolescents moving from ratings of ‘3’ (dangerous or disabling requiring immediate or intensive services) to ratings of ‘2’ (requires action) or ‘1’ (watchful waiting/prevention). This is exactly the pattern of results expected for a crisis intervention program. In crisis intervention services, children and youth should move from ‘immediate/intensive’ needs to ‘actionable’ needs. For the most part, a very small percentage of children and youth exit SASS services with immediate/intensive

service needs. However, the vast majority exit SASS with some actionable service needs. For example, nearly half (46%) have continued treatment needs for Emotional Disturbance (e.g., depression and/or anxiety).

Interestingly, it appears that SASS has little or no impact on Substance Abuse. This is not surprising since the program was not designed for youth with these needs. Also, from these data, it appears that SASS has little impact on sexual-related problems as neither Sexual Aggression nor Sexual Development demonstrated significant improvements.

Figure 3 presents the percentage of SASS children and adolescents who are assessed at a '2' or a '3' on each of the five symptom categories, in other words, a need for treatment. Fourteen percent of children and youth presented with actionable (i.e. treatment) rating of psychosis at screening. Only 8% remained at that level at termination suggesting a number of reactive psychoses that were managed during the SASS episode of care. Emotional Disturbance (e.g., depression and anxiety) was the second most common symptom area and generally remained an actionable need even at termination. This is a symptom area that SASS must address by linking to appropriate services for ongoing treatment. About 45% of cases terminated with ongoing actionable needs in this area. SASS appeared quite successful at resolving issues of impulsivity. Nearly two thirds (63%) presented at screening with this need but only 37% still had an actionable level of assessed impulsivity at termination. Disruptive behavior disorders (Conduct and Oppositional) are relatively common and demonstrate significant improvements over the course of a SASS episode of care. However, it remains the case that for both children and adolescents with these problems at screening, the majority still have these needs at termination.

Figure 3. Percent of SASS children and adolescents with an actionable symptom at screening and termination

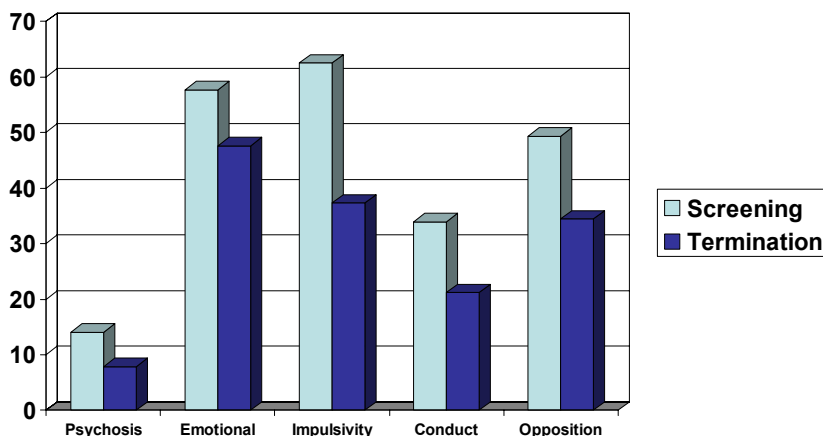
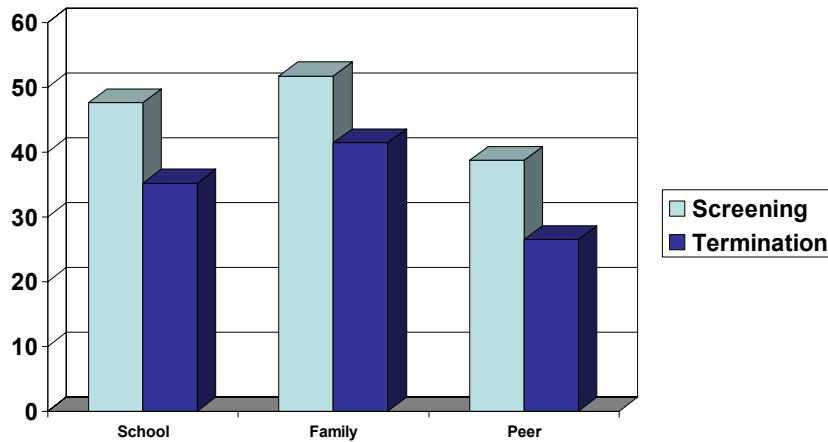


Figure 4 presents a similar analysis for the five risk behaviors assessed with the CSPI. Review of this table demonstrates the primary impact of the SASS episode of care. In most cases, issues of Suicide Risk and Danger to Others are resolved within the SASS episode of care and only remained as issues to be monitored and/or prevented from recurring. Each of these risk behavior is 'actionable' in about one third of cases. Elopement is a need in 25% of cases but it not as commonly resolved during a SASS episode of care. Crime/delinquency and Sexual Aggression are both less frequent treatment needs and in most cases remain needs at the termination of the SASS episode.

Figure 5 presents an item level analysis for the three functioning domains assessed by the CSPI. Review of these data suggests that while a number of children and adolescents resolve functioning problems, in the majority of cases, functioning needs presented at screening remain 'actionable' (i.e. treatment or

service) needs at termination from SASS services. This finding is not surprising in that most research suggests that improvement in functioning domains is the hardest outcome to achieve for behavioral health services. *Despite this challenge, these results suggest that SASS involvement is associated with functional improvement.*

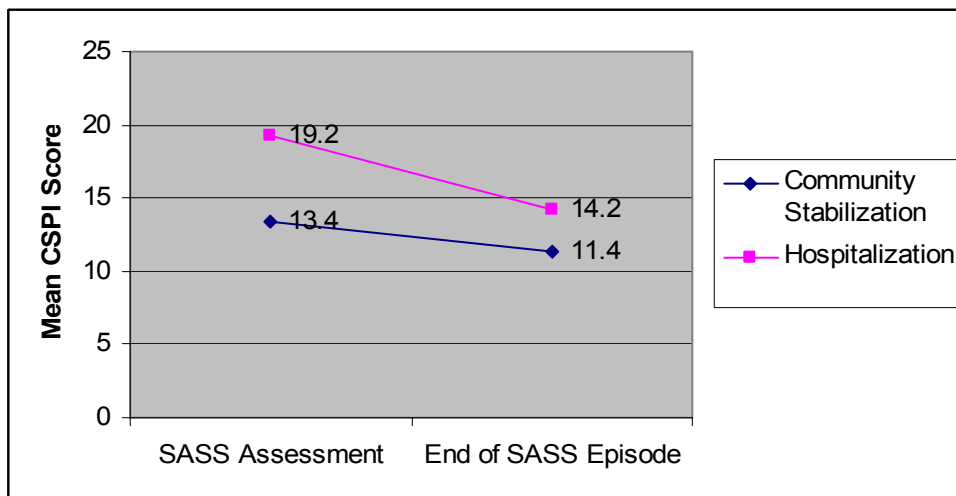
Figure 5. Percent of SASS children and adolescents with an actionable functioning at screening and termination



Comparison of Hospital Outcomes to Intensive Community Intervention

Although it is clear from the decision analyses that children and youth who are hospitalized have significantly more needs than those who are treated with intensive community services (as also shown in Figure 6), methods exist that allow for a direct comparison of the outcomes associated with these two treatment approaches.

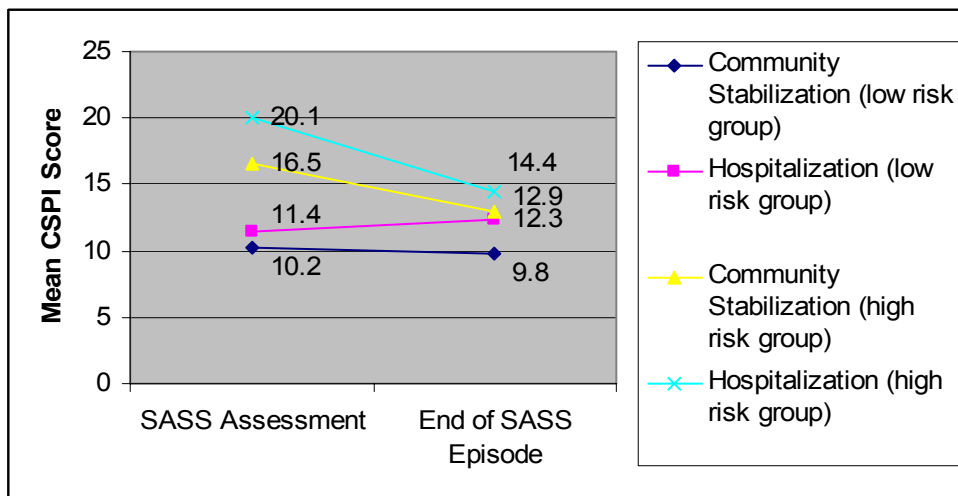
Figure 6. Change in Total CSPI Score Among Children With a SASS Episode (FY05)



Propensity score analysis is a method developed by health services researchers that allows for the statistical matching of individuals across treatment types to allow for direct comparisons of outcomes. We applied propensity score analysis by matching on demographic and clinical variables until the criteria for a valid comparison was met. For the full sample, receiving intensive community services was associated with statistically significantly better outcomes (i.e., reduction in total CSPI score) compared to psychiatric hospitalization ($B=-0.664$, 95% CI = $[-1.344, -0.126]$, $t=-2.06$). This means that in a relative comparison across all children and youth served by SASS, intensive community services was associated with overall better clinical and functional improvement among those served.

We subdivided the sample into those who were predicted by the CSPI to be hospitalized and those who were predicted to be served in the community. The change in CSPI scores from assessment to the end of the SASS episode are shown in Figure 7. Propensity score analysis was again performed, this time separately for each of these two clinical samples. In these analyses, hospitalization was associated with statistically better outcomes for the high-risk children and youth (i.e., those predicted to be hospitalized) than community stabilization ($B=1.989$, 95% CI = $[1.363, 2.594]$, $t=6.04$). For the lower-risk children and youth, intensive community services were associated with statistically better outcomes than hospitalization ($B=-1.195$, 95% CI = $[-2.346, -0.017]$, $t=-2.03$). Further research is needed to determine the clinical cut-point at which psychiatric hospitalization becomes a more effective intervention than intensive community services.

Figure 7. Change in Total CSPI Score by Intervention and Hospitalization Risk Level (FY05)



VII. PARTNER PERSPECTIVES

The SASS program was designed to operate within the fabric of the children's mental health service system. In fact, one of the state goals of the program is to improve the coordination of services within the system. As such, SASS services touch many people, and understanding the impact of the current SASS program should include some attention given to the perspectives of these various system partners. For the evaluation of the first year of the current SASS program, four perspectives were

identified: parents/caregivers, SASS agencies/programs, hospitals, and community behavioral health providers. This section of the evaluation presents the results of surveys designed to assess the experience of each of these partners within the first year of SASS. Clearly, other important perspectives exist, including the youth's perspective, SASS worker's perspective, school's perspective, etc. Time and resources limited our capacity to sample all of these perspectives in the first year of the program.

Parents'/Caregivers' Perspective

In order to maintain compliance with rules and regulations which require that all surveys be initiated by the health care provider, we surveyed parents and caregivers by having SASS workers distribute questionnaires in March 2005 to parents or caregivers whose children they had served. A Spanish language version of the questionnaire was available when needed. Potential respondents were given a stamped envelope addressed to the Mental Health Services and Policy Program of Northwestern University. A total of 240 parents/caregivers responded to the questionnaire. Given the method used to recruit respondents it was not possible to estimate the response rate (i.e. the percentage of caregivers who were given a survey compared to those who completed it).

Of the respondents, 62.1% were Caucasian, 24.4% were African American, 12% were Hispanic, and 0.4% were Asian. Respondents came from 51 different counties. Twelve respondents used the Spanish language version. The majority were biological parents (69%); however, 9.3% were legal guardians, 8.4% were adoptive parents, and 4.0% were foster parents. This profile is roughly comparable to the percentages observed for the population of children and families served. Table 7 presents the results for each of the specific questions on the survey. In addition, the respondents were asked for open-ended comments. Appendix B contains a listing of all comments.

Table 7. Percent of Parents/Caregivers responding to each of the possible levels of satisfaction to survey questions.

	Poor	Fair	Good	Excellent
Getting SASS services during your child's crisis				
How the CARES line responded to your concerns	4.3	9.1	37.6	48.9
How quickly SASS responded	4.4	9.2	29.7	56.8
How open the SASS worker was to your perspective and wishes	3.9	6.4	23.2	66.5
The availability of services to address your child's needs	6.4	10.7	28.8	54.1
How simple it was to make SASS follow-up appointments	4.8	7.0	33.0	55.0
The consistency with which SASS followed up with you after the initial crisis	8.4	7.9	27.3	56.4

Appropriateness and Sensitivity

SASS worker's sensitivity to your cultural, racial, gender, religious needs	2.3	3.6	29.7	64.4
Respect with which you and your children were treated	2.7	3.5	19.9	73.9
SASS worker's ability to speak in your language	1.4	0.5	20.7	77.4
SASS worker's ability to identify your child's strengths and skills	4.6	5.5	29.0	61.0
The opportunity for you and your Child to be involved in his/her SASS care planning	7.7	6.4	29.5	56.4
The plan you and your child developed to manage the crisis	7.4	9.1	33.5	50.0

Outcomes

Help your ability to manage your child's behavior	8.3	18.4	36.8	36.4
Help your child's ability to manage his/her own behavior	9.7	20.4	35.0	35.0
Impact of SASS services on your child's safety	6.6	8.8	36.1	48.5
Help with child's relationship to you and other in home	10.8	16.1	37.7	35.4
Overall improvement your child has made	10.1	21.1	38.8	30.0

Global Satisfaction

Overall quality of SASS services received by your child	6.3	6.7	34.5	52.5
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It appears that generally parents/caregivers are quite satisfied with the CARES line. Approximately one in five parents/caregivers did not answer the question regarding CARES. This reflects the fact that in a number of cases, parents are not the individuals who contact the CARES line seeking a SASS referral. In about one in five cases, the parent/caregiver had no role in this contact. However, in the about 7 in 10 cases (nearly 90% of those parents/caregivers who were involved), they experienced CARES as 'good' or 'excellent.' The parent/caregiver responses can be summarized as follows:

- In general, parents/caregivers were pleased with their access to SASS. Services were prompt and open to the parent's perspective, and were seen as consistent and useful in linkage and follow-up services.
- SASS workers were overwhelmingly seen as culturally sensitive, respectful, and strength-based. They were seen as helpful in the crisis and allowed a sufficient level of family involvement in care planning.
- The SASS experience was seen as generally helpful. Outcome satisfaction was a little lower than satisfaction with access and quality, but parents clearly saw SASS as helping to keep their children safe. Parents/caregivers also generally felt better able to manage their children's behavior, their children improved self-management of behavior, and relationships improved at home.
- The overall satisfaction with SASS was high: 87% rated it as 'good' or 'excellent.'

SASS Program Perspective

Two perspectives were solicited within SASS programs—the first was an agency director’s perspective and the second the SASS program director’s perspective. Both SASS contractors and subcontractors were sampled for this survey, resulting in a possible sample of 52 respondents for both perspectives.

Agency Directors. Agency Directors were identified for every agency that was contracted to provide SASS services and all agencies identified as subcontractors to these contracted agencies. They were surveyed by mail in February-March 2005. A total of 28 of 52 (54%) agency directors responded to the survey. Ten responded from Central Illinois, eight from Southern Illinois, three from Cook, four from the collar counties around Cook, and three from Northern Illinois. These agencies had a median three full-time and one part-time SASS workers, although the range was considerable.

Table 8. Percent of Agency Directors endorsing the four levels of satisfaction with each item on the survey.

	Poor	Fair	Good	Excellent
Access to SASS Services				
The responsiveness of the CARES line to your concerns	7.1	42.9	42.9	7.1
The appropriateness of referrals from CARES	0.0	28.6	46.4	25.0
The timelessness and completeness of referrals from CARES	10.7	25.0	50.0	14.3
The ability to recruit SASS workers in your agency	12.5	29.2	50.0	8.3
The ability to retain SASS workers in your agency	7.7	23.1	46.2	23.1
The clarity of rules for SASS services	17.9	57.1	14.3	10.7
The responsiveness of the state to provider concerns	46.4	32.1	7.1	14.3
Reimbursement				
The speed of reimbursement from Medicaid	78.6	10.7	7.1	3.6
The amount of reimbursement from Medicaid	60.7	32.1	7.2	0.0
The degree to which the SASS business model fits the clinical model	46.4	39.3	10.7	3.6
Evaluation of SASS Services				
The burden of the Northwestern evaluation effort	11.1	44.4	37.0	7.4
The appropriateness of the CSPI for monitoring the status of children served in SASS	25.0	28.6	35.7	10.7
Support for training and technical assistance	17.9	42.9	10.7	28.6

The responsiveness of the evaluation team to your concerns	14.8	33.3	25.9	14.8
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Global

Overall quality of the SASS services that you provide	0.0	25.0	70.0	5.0
Overall, how satisfied are you with the SASS expansion at this stage of its implementation	46.4	35.7	10.7	7.1

In general, Agency Directors of agencies with SASS programs appear reasonably satisfied with the CARES line. There are some concerns about the responsiveness of the CARES lines to SASS agency concerns as nearly half of all respondents rated this item as Fair or Poor. The main concern of Agency Directors regards the speed and amount of reimbursement from Medicaid for SASS services. This perception is also manifest in the fact that the vast majority (86%) view the fit of the SASS business model and its clinical model as a 'Fair' or 'Poor' fit. This survey was taken before some agencies had successfully shifted to the fee-for-service system so it will be important to track whether this is an implementation issue or a permanent problem with the model. Regardless of these concerns 75% of Agencies Directors thought that the quality of their SASS services was either 'Good' or 'Excellent.' However, primarily because of the financial aspects of the SASS program, Agency Directors are overall not particularly satisfied with the SASS program at the time of the survey as more than 80% rated it as 'Fair' or 'Poor.'

SASS Program Directors. SASS Program Directors were identified and sent surveys in February-March 2005. Respondents were given a stamped envelope and asked to return their surveys to the Mental Health Services and Policy Program at Northwestern University. A total of 32 of 52 (62%) Program Directors responded to the survey. Eleven programs in Central Illinois responded, 10 in Cook, four in both Northwestern and Southern Illinois, and three in the collar counties surrounding Cook.

Table 9. Percent of SASS Program Directors endorsing the four levels of satisfaction with each item on the survey.

	Poor	Fair	Good	Excellent
Access to SASS Services				
The responsiveness of the CARES line to your concerns	9.4	42.2	38.7	6.5
The appropriateness of referrals from CARES	6.3	40.6	40.6	12.5
The timelessness and completeness of referrals from CARES	12.5	37.5	40.6	9.4
The ability to recruit SASS workers in your agency	14.8	29.6	40.7	14.8
The ability to retain SASS workers in your agency	9.4	9.4	27.4	34.4
The clarity of rules for SASS services	21.9	31.3	40.6	6.3
The responsiveness of the state to provider concerns	37.5	46.9	9.4	6.3
Financial Aspects				
Your ability to pay staff enough to recruit and retain good people	31.3	46.8	15.6	6.3
The financial viability of the SASS program	53.1	37.5	6.3	3.1
The degree to which the SASS business model fits the clinical model	62.5	21.9	15.6	0.0

Table 9 Continued

	Poor	Fair	Good	Excellent
Evaluation of SASS Services				
The burden of the Northwestern evaluation effort	11.1	44.4	40.7	3.7
The appropriateness of the CSPI for monitoring the status of children served in SASS	9.4	50.0	37.5	3.1
Support for training and technical assistance	6.3	46.9	34.4	12.5
The responsiveness of the evaluation team to your concerns	15.4	30.8	42.3	11.5
Outcomes of SASS Services				
Impact of SASS services on parent's ability to help manage child's behavior	3.1	31.3	59.5	6.3
Impact of SASS services on the child's ability to manage his/her own behavior	0.0	28.1	65.6	6.3
Impact of SASS on the child's safety	0.0	6.3	65.6	28.1
Impact of SASS on the child's relationship with family and others in the home	0.0	31.3	59.4	9.4
Overall improvement children make during SASS episode	0.0	31.3	59.4	9.4
Global				
Overall quality of the SASS services that you provide	3.1	12.9	58.1	25.8
Overall, how satisfied are you with the SASS expansion at this stage of its implementation	34.4	48.8	18.8	3.4

In general, SASS Program Directors were somewhat more satisfied with the SASS program than were their Agency Directors. Generally, the CARES line performance was rated in the 'Fair' to 'Good' range. Program Directors shared their Agency Directors' perspective on the financial aspects of the SASS program. In general, there was dissatisfaction with the fit between the business model and the clinical model. However, SASS Program Directors perceive their services to be effective and of 'Good' to 'Excellent' quality.

Hospital Perspective

Seventy hospitals were identified that might admit children with psychiatric disorders or at minimum assess them in their emergency departments. Of these, 55 (79%) were successfully contacted by phone in July-August 2005. Representatives of 20 of these hospitals felt that they had no experience

with SASS or such minimal experience that they could not reasonably provide an evaluation perspective. Thirty-five hospitals did have representatives who felt sufficiently experienced with SASS to comment on the program. A total of 40 individuals representing these 35 hospitals participated in the survey.

Nearly half (46%) of the hospital respondents (16) were located in Cook County and an additional six (15%) were located in the surrounding counties. Ten hospital respondents (25%) were located in Central Illinois. Six hospital representatives from Northern Illinois participated. No hospitals from Southern Illinois were represented in the survey.

Over half (63%) of the hospitals admitted children (22). Sixteen of these were general hospitals with child and adolescent units and six were stand alone psychiatric hospitals. Of the remainder, seven were general hospitals without units and six were general hospitals with only adult psychiatric admissions.

Most respondents were social workers, crisis workers, case managers, or nursing staff. Great effort was made to identify the most appropriate hospital respondent for the survey. Twenty-eight percent of respondents stated they had very frequent contact with CARES and SASS. Thirty percent stated that they had frequent contact. Twenty percent of respondents stated they had somewhat frequent contact and 20% said they had infrequent contact. Table 10 presents the overall data across all hospital representatives.

Table 10. Percent of Hospital Representatives endorsing the four levels of satisfaction with each item on the survey.

	Poor	Fair	Good	Excellent
Overall Quality of CARES Line	10	38	47	5
Overall SASS Quality	13	21	43	23
Satisfaction with the timeliness of the SASS response	Dissatisfied 13		Neutral 10	Satisfied 48
				Extremely Satisfied 23

Review of these data suggests that, in general, representatives of the hospital perspective are satisfied with CARES and SASS. Their assessment of SASS quality is higher than their assessment of CARES quality. Review of comments (see the Appendix) suggests that variability in the quality and professionalism of CARES staff might account for some of this difference. A significant minority of respondents were not convinced that CARES line staff have sufficient qualifications to make the judgments they are making in the current program design (n=10, 25%).

Looking at satisfaction by hospital type, it is clear that psychiatric hospitals are less satisfied with CARES and SASS than other hospitals. No representative rated either CARES or SASS quality as 'excellent,' compared to about 25% of respondents of other hospital types. In addition, hospitals with child and adolescent units were less satisfied than general hospitals that did not admit children (18% versus 0% rating SASS overall quality 'poor').

It is recommended that reading all the comments available in the Appendix is a helpful method for those wishing to get a good feel for how hospital representatives evaluate CARES and SASS. In general, it is a positive assessment. However, hospitals that have child and adolescent beds or units are less satisfied with SASS than hospitals that do not admit children and adolescents. There are likely at least two possible reasons for this disparity:

1. Hospitals which admit children and adolescents have a higher level of expertise in clinical assessment and treatment. It would be natural for these hospitals to view the CARES and SASS processes as an intrusion in a clinical process in which they feel they bring considerable expertise.
2. There is an essential financial conflict of interest when hospitals provide crisis assessments and hospital admissions because in order to make a hospital business model work, it is necessary to keep hospital admissions high enough to maintain bed census. Thus any process that threatens a reduction in hospital admissions might be seen as a threat to the financial viability of the hospital unit.

Community Mental Health Provider Perspective

Community Mental Health Centers that do not have SASS programs represent another important perspective in understanding the functioning of the SASS programs. These community providers are sometimes primary referral sources through the CARES line to engage SASS services for clients they serve.

Sixty-six community agencies were identified from lists provided by the Department of Human Services. Surveys were sent to each of these agencies in July 2005 and 34 responded (52%). Table 11 presents the findings from the satisfaction ratings on this survey.

Table 11. Percent of Community Mental Health Providers endorsing the four levels of satisfaction with each item on the survey.

	Poor	Fair	Good	Excellent
Access to SASS Services				
The responsiveness of the CARES line to your agency	0.0	33.3	46.7	20.0
The appropriateness of CARES dispositions	3.2	38.7	35.5	22.6
The timelessness and completeness of referrals from CARES	9.7	22.6	51.6	16.1
The clarity of rules for SASS referrals	21.2	39.4	33.3	6.1
The responsiveness of the state to provider concerns about CARES and SASS	29.6	40.7	22.2	7.4

Table 11 Continued

	Poor	Fair	Good	Excellent
Appropriateness and Sensitivity				
SASS worker's sensitivity to the child's cultural, racial, gender, religious needs	0.0	19.4	54.8	25.8
Respect with which the child and family were treated	6.5	19.4	48.4	25.8
Respect with which your staff were treated	9.4	12.5	41.9	32.3
SASS worker's ability to speak the family's language	0.0	12.0	64.0	24.0
The opportunity for your staff to be involved in the SASS care planning	38.7	22.6	25.8	12.9
The plan developed to manage future crises	25.0	43.8	25.0	6.3

Outcomes of SASS Services

Help the parent/caregiver's
ability to help manage their child's
behavior

23.3 40.0 33.3 3.3

Help the child's ability to manage
his/her own behavior

20.0 40.0 40.0 0.0

Impact of SASS on the child's
safety

13.3 33.3 40.0 13.3

Impact on your agency's ability
to serve the child and family

20.0 40.0 40.0 0.0

Overall improvement children
make during SASS episode

25.8 32.3 32.3 9.7

Global

Overall quality of the CARES
interactions that your agency has
experienced

18.8 18.8 50.0 12.5

Overall quality of the SASS
services your agency has
experienced

18.8 34.4 37.5 9.4

It appears from the findings above that the community providers are the least satisfied of any of the partners with the CARES and SASS program. In particular, the 39% 'poor' rating with regard to SASS involving the community providers in the service planning process is notable. This might suggest that in SASS' efforts to be more inclusive with parents and youth in regard to service planning, they have been less successful in fully including community providers in this process. The parent survey indicates that caregivers are generally satisfied with being included, while the community provider survey indicates an area for improvement.

Community providers are somewhat less satisfied with the responsiveness of the CARES line and with the dispositions made by CARES compared with other partners. Similar to the hospital survey, it does appear that other professionals who are expert in the treatment of children and adolescents are often unhappy with another professional evaluating (e.g., 'second guessing') their attempt to refer a child to SASS. Similarly, the community providers are not particularly satisfied with SASS' plan for future crises. Of course, given their perceived lack of involvement in the planning process, it is not surprising that they are generally dissatisfied with the outcomes of that process.

VIII. SUMMARY AND RECOMMENDATIONS

The totality of the evaluation data presented above suggests that the implementation of the CARES line and the provision of SASS services to all Medicaid eligible children and adolescents has been a qualified success:

- A substantial number of children and adolescents have been served.
- Parents are generally pleased with the services.
- SASS providers feel that they are able to deliver a high quality product.
- Other system partners are generally satisfied with SASS.
- Decision-making with regard to the use of intensive community services and psychiatric hospitalization appears to be rational.
- Outcomes are generally good. Intensive community interventions appear to be particularly effective at reducing symptoms and risk behaviors and improving functioning.

There do appear to be some areas for improvement. These can be summarized as follows:

- Providers who also serve children and adolescents do not always feel included in the SASS service delivery process.
- There is some variable concern about the professionalism of the CARES line staff and the manner in which they interact with referring individuals.
- SASS providers have some concerns about the viability of the business model and some have struggled to shift to a fee-for-service model.
- Variation across providers in terms of both decision-making and outcomes suggest that the SASS model has not been consistently implemented across the state.

While the evaluation effort this year has attempted to pull together data from multiple sources and address the most pressing questions with regard to understanding the impact of SASS on children and families, a number of questions remain unanswered. Among the questions that should be addressed through future evaluation efforts are the following:

- What is the youth perspective on CARES and SASS services?
- What is the differential parent/caregiver perspectives on intensive community services versus psychiatric hospital treatment?
- What is the cut-point at which the clinical benefits of psychiatric hospitalization outweigh those of intensive community interventions? Can that decision-model be communicated to SASS providers and psychiatrists in a way that improves practice?
- Can provider performance be improved through the use of report cards and other feedback and technical assistance strategies?
- Can we better understand racial and cultural factors? Why do African American children and youth present at a higher level of need? Why do Native Americans fair poorly?

The results of the present evaluation indicate that SASS is an effective program with a number of addressable issues identified that, if resolved, could lead it to be an even more effective program. Clearly FY06 priorities should include improving communication and collaboration, ensuring that the business model and the clinical model reinforce each other, and addressing performance variability among providers.

APPENDIX A: Childhood Severity of Psychiatric Illness Manual

APPENDIX B: Individual Comments from Satisfaction Surveys

**CHILDHOOD
SEVERITY OF PSYCHIATRIC ILLNESS**

MANUAL

Mental Health Services and Policy Program
Department of Psychiatry & Behavior Science
Northwestern University Medical School
and the
Department of Child and Adolescent Psychiatry
Children's Memorial Hospital

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Childhood Severity of Psychiatric Illness

About the Measure

The Childhood Severity of Psychiatric Illness (CSPI) is an assessment tool developed to assist in the management and planning of mental health services for children and adolescents. Developed as a decision support tool for case managers and clinical decision-makers, the CSPI provides for the structured assessment of children with possible mental health service needs along a set of dimensions found to be relevant to clinical decision making. In addition, the measure is designed to provide information regarding children's mental health needs for utilization during service system planning and quality assurance monitoring.

The dimensions and objective anchors used in the CSPI were developed through focus groups with a variety of participants including representatives of the provider community and DCFS case workers and staff. From these discussions, pilot instruments were developed and tested in a number of sites. The reliability of the CSPI has been found to be quite high for trained raters and the dimensions have been shown to reliably predict both mental health service use and clinical outcomes.

A summary of the dimensions of the CSPI can be found below. Each of these dimensions is rated on 4-point scales after routine clinical contact or following review of case files. Although the anchors of each of these scales varies, the basic design is that a zero reflects no evidence, a rating of one reflects a mild degree of the dimension, a rating of 2 reflects a moderate degree and a rating of 3 reflects a severe or profound degree of the dimension. The basic structure of the CSPI is as follows:

Symptoms:

- Neuropsychiatric Disturbance
- Emotional Disturbance
- Conduct Disturbance
- Oppositional Behavior
- Impulsivity
- Contextual Consistency of Symptoms
- Temporal Consistency of Symptoms

Risk Factors*:

- Suicide Risk
- Danger to Others
- Elopement Risk
- Crime/Delinquency
- Sexual Aggression

Functioning:

- School Dysfunction
- Family Dysfunction
- Peer Dysfunction

Co-morbidity:

Adjustment to Original Trauma/Separation
Medical
Substance Abuse
Severity of Abuse
Sexual Development
Learning and Developmental Disabilities

Systems Factors:

Caregiver Ability to Provide Supervision
Caregiver Motivation for Change
Caregiver Knowledge of Child
Placement Safety
Community Capacity for WRAP Services
Multi-System Needs

***For Risk Factors, use 7 days prior to admission for rating. For all other scales, use 30 days prior to admission.**

For more information, please contact:

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Definitions of Item Rating Levels

SYMPTOMS

Neuropsychiatric Disturbance. This dimension is used to rate symptoms of psychiatric disorders with a known neurological base. DSM-IV disorders included on this dimension are Schizophrenia, Psychotic disorders (unipolar, bipolar, NOS), Autism, and some encephalopathies. The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, bizarre/idiosyncratic behavior.

- 0 This level indicates a child with no evidence of thought disturbances. Both thought processes and content are within normal range.
- 1 This level indicates a child with evidence of mild disruption in thought processes or content. The child may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This level also includes children with a history of hallucinations but none currently. This category would be used for children who are subthreshold for one of the DSM diagnoses listed above.
- 2 This level indicates a child with evidence of notable disturbance in thought process or content. The child may be somewhat delusional or have brief or intermittent hallucinations. The child's speech may be, at times, quite tangential or illogical. This level would be used for children who meet the diagnostic criteria for one of the disorders listed above.
- 3 This level indicates a child with severe thought disorder. The child frequently experiences symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. Command hallucinations would also be coded here. This level is used for extreme cases of the diagnoses listed above.

Schizophrenia

A. Characteristic Symptoms:

(Two or more of the following, unless severe delusions or hallucinations, for a significant portion of time during a one month period):

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms (i.e. affective flattening)

B. Social/Occupational Dysfunction:

Failure to achieve expected level of self-care or interpersonal, academic, or occupational achievement.

C. Duration:

Continuous signs of the disturbance persist for at least six months (must include at least one month of symptoms, unless successfully treated).

Autism

A. Characteristic Symptoms:

(Six or more items with at least two from (1), and one from (2) and (3)).

1) Impairment in Social Interaction:

- marked impairment in the use of multiple nonverbal behaviors
- failure to develop peer relationships
- lack of shared enjoyment, interests, or achievements with other people

2) Impairments in Communication:

- delay or total lack of development of spoken language
- impairment in ability to initiate or sustain a conversation
- stereotyped and repetitive or idiosyncratic use of language
- lack of age-appropriate make-believe or social imitative play

3) Restricted Repetitive and Stereotyped Patterns of Behavior,

Interests, and Activities:

- preoccupation with stereotyped and restricted patterns of interests that is abnormal in intensity or focus
- inflexible adherence to routines or rituals
- stereotyped and repetitive motor mannerisms
- persistent preoccupation with parts of objects

B. Delays or Abnormal Functioning:

(Onset prior to age 3)

- social interaction
- language as used as social communication
- symbolic or imaginative play

Emotional Disturbance This dimension is used to rate symptoms of the follow psychiatric disorders as specified in DSM-IV: Depression (unipolar, dysthymia, NOS), Bipolar, Intermittent Explosive Disorder, Generalized Anxiety, Eating Disorders, Phobias. Symptoms included in this dimension are depressed mood, social withdrawal, anxious mood, sleep disturbances, weight/eating disturbances, loss of motivation.

- 0 This rating is given to a child with no emotional problems. No evidence of depression or anxiety.
- 1 This rating is given to a child with mild to moderate emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior. This level is used to rate either a mild phobia or anxiety problem or a subthreshold level of symptoms for the other listed disorders.
- 2 This rating is given to a child with a moderate to severe level of emotional disturbance. This could include major conversion symptoms, frequent anxiety attacks, obsessive rituals, flashbacks, hypervigilance, depression, or school avoidance. Any diagnosis of anxiety or depression should be coded here (regardless of severity). This level is used to rate children who meet the criteria for an affective disorder listed above.
- 3 This rating is given to a child with a very severe level of emotional disturbance. This would include a child who stays at home or in bed all day due to anxiety or depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. More severe forms of anxiety or depressive diagnoses would be coded here (e.g., meeting criteria in excess of the diagnosis). This level is used to indicate an extreme case of one of the disorders listed above.

Generalized Anxiety Disorder

A. Excessive anxiety and worry about a number of events or activities (occurring more days than not for at least six months).

B. Worry is difficult to control

C. *Characteristic Symptoms:*

(One or more of the following):

- restlessness
- easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- sleep disturbance

- fatigue

- feelings of worthlessness or inappropriate guilt nearly every day

- diminished ability to think or concentrate or indecisiveness nearly

every day

- recurrent thoughts of death, suicidal ideation or attempt

Major Depressive Disorder

A. *Characteristic Symptoms:*

(5 or more of the following present during a two-week period. Must include either depressed mood or loss of interest or pleasure):

- depressed or irritable mood (most of the day, nearly every day)
- markedly diminished interest or pleasure in activities (most of the day, nearly every day)
- significant weight loss or gains (or failure to meet expected weight gains)
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day

Conduct Disturbance (Antisocial behavior) This dimension includes the symptoms of conduct disorder as specified in DSM-IV. These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, assault.

- 0 This level indicates a child with no evidence of behavior disorder.
- 1 This level indicates a child with a mild or moderate level of conduct problems. Some difficulties in school and home behavior. Problems recognizable but not notably deviant for age and sex and community. This might include occasional truancy, lying or petty theft from family.
- 2 This level indicates a child with a moderate to severe level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child rated at this level should meet the criteria for a diagnosis of conduct disorder.
- 3 This level indicates a child with a very severe conduct disorder. This could include frequent episodes of unprovoked, planned aggressive or other antisocial behavior.

Conduct Disorder (Three or more of the following in the last 12 months w/ at least one in the last 6 months):

Aggression to people and animals

- bullies, threatens, or intimidates others
- initiates physical fights
- has used a weapon that can cause serious physical harm to others
- has been physically cruel to people
- has stolen while confronting a victim (mugging, extortion, armed robbery, purse snatching)
- has forced someone into sexual activity

Serious Violations of Rules

- often stays out at night despite parental prohibitions (beginning before age 13)
- has run away from home overnight at least twice (or once without returning for a lengthy period)
- often truant from school (beginning before age 13)

Destruction of Property

- engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property

Deceitfulness of Theft

- has broken into someone's house, building, car
- lies to obtains goods or favors (i.e. "cons" others)
- has stole items of nontrivial value without confronting victim

Oppositional Behavior (Compliance with authority) This dimension is intended to capture how the child relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance to authority rather than on seriously breaking social rules, norms, and laws.

- 0 This level indicates that the child is generally compliant.
- 1 This level indicates that the child is occasionally noncompliant to some rules or adult instructions.
- 2 This level indicates that the child is frequently noncompliant to rules or adult instructions. A child rated at this level should meet the criteria for Oppositional Defiant Disorder in DSM-IV.

- 3 This level indicates that the child is virtually always noncompliant to rules or adult instructions. A child rated at this level would be a severe case of Oppositional Defiant Disorder.

Oppositional Defiant Disorder

A. Characteristic Symptoms:

(4 or more of the following for at least 6 months):

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- is often touchy or easily annoyed by others
- is often angry or resentful
- is often spiteful or vindictive

Impulsivity In addition to impulsive behavior, symptoms of Attention Deficit and Hyperactivity Disorder and Impulse Control Disorder would be rated here. Inattention/distractibility not related to opposition would also be rated here.

- 0 This rating is used to indicate a child with no evidence of impulse control problems.
- 1 This rating is used to indicate a child with some evidence of mild problems with impulse control. This could be infrequent impulsive action that does not pose notable safety risk, but where the child clearly did not consider consequences. Occasional tantrums or angry outbursts might be rated here.
- 2 This rating is used to indicate a child with considerable impulse control problems. Frequent impulsive behavior is observed or reported that carries some safety risk. A child who meets DSM-IV diagnostic criteria for ADHD or Impulse Control Disorder would be rated here.
- 3 This rating is used to indicate a child with severe impairment of impulse control. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g. running into the street, dangerous driving or bike riding). A child with profound symptoms of ADHD or Impulse Control Disorder would be rated here.

ADHD

A. Characteristic Symptoms:

(6 or more of the following for at least 6 months):

Inattention Often:

- fails to pay attention to details or makes careless mistakes in schoolwork, or other activities
- has difficulty sustaining attention in tasks or play
- does not seem to listen when spoken to
- does not follow through on instructions and fails to finish schoolwork or chores
- has difficulty organizing tasks and activities
- avoids tasks that require sustained mental effort
- loses things necessary for tasks or activities
- easily distracted by extraneous stimuli
- forgetful in daily activities

Hyperactivity Often:

- fidgets with hands or feet or squirms in seat
- has difficulty remaining seated when expected
- runs and climbs excessively or subjective feelings of restlessness
- has difficulty playing quietly
- is "on the go" or acts as if "driven by a motor"
- talks excessively

Impulsivity Often:

- blurts out answers during questions
- has difficulty awaiting turn
- interrupts or intrudes on others

- B. Some symptoms present before age 7.
- C. Some impairment present in two or more settings.

Impulse Control Disorders Symptoms:

Several discrete episodes of failure to resist:

- aggressive impulses that result in serious
- assaultive acts or destruction of property
- impulses to steal objects that are not needed
- impulses to deliberately, purposefully set fires

Contextual Consistency of Symptoms

- 0 This level is used for a child who is symptomatic primarily in one location (e.g. school or home only) and minimally symptomatic in another setting.
- 1 This level is used for a child who is symptomatic in an unstructured setting but who becomes minimally symptomatic when placed in highly structured settings.
- 2 This level is used to represent a child who is symptomatic across most settings regardless of structure or circumstance, but who demonstrates notable variability in symptom type or intensity by context.
- 3 This level indicates a child who is consistently symptomatic regardless of environmental context.

Temporal Consistency of Symptoms

- 0 This level indicates a child who is not symptomatic or who has developed symptomatology only in the past three months as the result of a clear stressor.
- 1 This level indicates a child who has become symptomatic in the past two years but has remained at least somewhat symptomatic during this time or a child who has become symptomatic in the past three months despite the absence of any clear stressors.
- 2 This level indicates a child who has been symptomatic for an extended period of time (e.g. more than two years), but who has had significant symptom-free periods.
- 3 This level indicates a child who has been symptomatic for an extended period of time (e.g. more than two years) without significant symptom-free periods.

RISK FACTORS

Suicide Risk

- 0 This rating is given to someone with no known history of either suicide attempts or ideation.
- 1 This rating is given to someone with (1) no current suicidal ideation, (2) no recent suicide attempts (last 7 days), and (3) a known history of either a suicide attempt or ideation.
- 2 This rating is given to someone with (1) current evidence of suicidal ideation or preoccupation including talking about death and threatening to kill oneself, (2) no recent suicide attempt (last 7 days) OR a prior suicide attempt in the last 7 days with no suicidal ideation in the past 48 hours.
- 3 This rating is given to someone with a recent suicide attempt (last 7 days) regardless of the potential lethality of the attempt AND current active suicidal ideation in the last 48 hours.

Danger to Others

- 0 This rating is given to someone with (1) no current physical aggressiveness (last 7 days) towards either people or property, (2) no current verbal aggressiveness, and (3) no known history of aggressive acts to either people or property.
- 1 This rating is given to someone with (1) no current physical aggressiveness but either (2) current (last 7 days) verbal aggressiveness (but not homicidal) or (3) a known history of aggressive acts to either people or property.
- 2 This rating is given to someone who is currently physically aggressive towards property or people regardless of verbal aggressiveness, but not at a level that risks significant injury (hospitalization) or death.
- 3 This rating is given to someone who is either currently (last 7 days) physically aggressive towards people to the extent that there is risk of causing significant injury or death or expressing homicidal threats or ideation. Command hallucinations to kill or injure someone would be coded here.

Elopement Risk. In general to classify as a runaway or elopement, the child is gone overnight or very late into the night. The exceptions to this would be runaway attempts where the child is found and returned quickly although it was clear that he/she intended to remain away for an extended period.

- 0 This rating is for a child with no history of running away and no ideation involving escaping from the present living situation and/or treatment.
- 1 This rating is for a child with no recent history of running away but who has expressed ideation about escaping present living situation or treatment. Child may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.
- 2 This rating is for a child who has run away from home once or run away from one treatment setting within the past year. Also rated here is a child who has run away to home (parental or relative) in the past year.
- 3 This rating is for a child who has (1) run away from home and/or treatment settings within the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is not a return to home of parent or relative.

Crime/Delinquency

- 0 No evidence of criminal or delinquent behavior or history.
- 1 No current evidence of criminal or delinquent behavior in the past year but a prior history. Minor vandalism (less than \$500) might be rated here even if in last 30 days.
- 2 Evidence of criminal or delinquent behavior in the past year although child not actively engaged in criminal behavior. This could include significant acts of vandalism (more than \$500). No known gang affiliation.
- 3 Recent evidence of criminal or delinquent behavior (last 30 days) or a child or adolescent with known gang affiliation.

Sexual Aggression

- 0 This level indicates a child or adolescent who has never been sexually aggressive or coerced another child or adolescent into sexual activity. No evidence of any history or current sexual aggression.
- 1 This level indicates a child or adolescent who has previously been sexually aggressive or coerced another child but has successfully completed a treatment program. None of the prior sexual activity involved forced or coerced intercourse or penetration.
- 2 This level is used to indicate a child or adolescent who has either (1) a history of sexual aggression that included forced or coerced intercourse/penetration but has successfully completed a treatment program or (2) has been sexually aggressive or coerced another child into sexual activity in the past year not including forced or coerced intercourse or penetration.
- 3 This level indicates a child or adolescent who has been sexually aggressive in the past year and has engaged in forced or coerced intercourse or penetration during this time.

FUNCTIONING

School Dysfunction

- 0 This rating is used to indicate a child who is performing at his/her appropriate level in school or less than school age.
- 1 This rating is used to indicate a child who is having mild to moderate problems at school. This could include underachievement, discipline problems, or a child in a special school doing well.
- 2 This rating is used to indicate a child with serious school difficulties that may include school suspension, frequent truancy, significant discipline problems, and/or underachievement (at the level of failing a grade).
- 3 This level indicates a child with very severe school problems. This could include failure to attend, dangerous discipline problems, a child not in school who is of school age, or a child in a special school who continues to have significant problems.

Family Dysfunction (rated based on individuals, including non-family members, living at home)

- 0 This level indicates a family that is functioning without notable problems. Conflicts arise but are handled appropriately. Communication is adequate. Roles, hierarchies, and boundaries are clear.
- 1 This rating is used to indicate a family with mild to moderate dysfunction. This could include considerable unresolved conflict, blurred or inappropriate hierarchies and/or boundaries (e.g. parents pull children into their marital conflict).
- 2 This level indicates a seriously dysfunctional family. This could include potentially dangerous conflict, serious acting out by family members, and very poor communication.
- 3 This level indicates a severely dysfunctional family characterized by abuse and/or violence or extremely inappropriate communication. Lack of provision of basic needs for child.

Peer Dysfunction

- 0 This rating is used to indicate a child with appropriate peer relations. He/she has at least one identifiable close friend and good relations with other peers.
- 1 This level indicates a child with mild to moderate dysfunction in peer relations. This may include an absence of any close friend, conflictual relationships, or withdrawal from peers.
- 2 This level indicates a child with serious dysfunction in peer relationships. The child may be a 'loner' with few social contacts or may have very conflictual relationships with most peers.
- 3 This level indicates a child with very severe dysfunction in peer relationships. This would include violence towards peers or a complete absence of meaningful social contact or exclusive association with a highly deviant peer group (e.g., gang involvement).

CO-MORBIDITY

Adjustment to Trauma/Separation

- 0 Child appears to have adjusted to separation from parent(s) without significant psychological effects.
- 1 Child has some mild adjustment problems to separation from parent(s) or as result of earlier abuse. Child may be somewhat distrustful or unwilling to talk about parent(s).
- 2 Child has marked adjustment problems associated either with separation from parent(s) or with prior abuse. Child may have nightmares or other notable symptoms of adjustment difficulties.
- 3 Child has post-traumatic stress difficulties as a result of either separation from parent(s) or prior abuse. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of PTSD.

PTSD

A. Traumatic Event:

(Both of the following are present):

- person exposed to traumatic event(s) in which actual or threat of death or serious injury to self or other.
- person's response involved intense fear, helplessness, or horror (may be expressed by children as disorganized or agitated behavior)

B. Persistent Re-experience of Event:

(1 or more of the following):

- recurrent, intrusive distressing recollections of event and may engage in repetitive play or daydreams in which themes or aspects of the trauma are expressed
- frightening dreams with or without specific content
- acting or feeling as if the traumatic event were recurring
- psychological distress at exposure to internal or external cues that resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that resemble traumatic event

C. Avoidance of Related Stimuli or Numbing of Responsiveness: (3 or more of the following):

- avoids conversations, thoughts, feelings associated with the trauma
- avoids activities, places or people reminiscent of trauma
- can't remember aspects of the trauma
- decreased interest/participation in normal activities
- feelings of detachment or estrangement
- restricted range of affect
- sense of foreshortened future

D. Persistent Symptoms Post Trauma:

(2 or more of the following):

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- startles easily

E. Duration:

-Symptoms for greater than one month

Medical

- 0 This rating is for someone who has no notable medical problems. A mild, untreated medical problem that does not affect the person's psychological status would be coded here.
- 1 This rating is for someone with mild to moderate medical problems that require treatment but are relatively independent of the psychiatric illness (e.g. sinusitis, broken arm).
- 2 This rating is for someone with a moderate to serious medical problem that both requires treatment and represents a mild to moderate complication to psychiatric treatment (e.g., diabetes, asthma, heart valve problem, or seizures). Non-symptomatic HIV infection would be rated here.
- 3 This rating is for someone with a life threatening medical condition that presents a significant complication to treatment management (e.g. cancer, leukemia, AIDS, or severe malnutrition secondary to anorexia).

Substance Abuse

- 0 This rating is for someone who has no notable substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or adolescent.
- 1 This rating is for someone with mild to moderate substance use problems that might occasionally present problems of living for the person (intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently maintaining abstinence.
- 2 This rating is for someone with a moderate to serious substance abuse problem that both requires treatment and interacts with and exacerbates the psychiatric illness. Substance abuse problem consistently interferes with the ability to function optimally but does not completely preclude functioning in an unstructured setting.
- 3 This rating is for someone with an extreme substance dependence condition that presents a significant complication to the inpatient management (including need for detoxification, substance abuse in residential facility, and so forth).

Severity of Abuse / Neglect

- 0 This level is used to indicate a child with no history of any form of physical or sexual abuse, nor any history of neglect.
- 1 This level is used to indicate a child with a history of mild abuse or neglect. This could include a child who is occasionally hit or touched inappropriately. Occasional neglect would also be rated here such as leaving a child at home with no adult supervision.
- 2 This level is used to indicate a child with a moderate level of abuse. This would include a child who has been fondled on an ongoing basis but not penetrated. However, this might also include a child who has been penetrated on one occasion. This would also include a child who is physically abused on an ongoing basis and may require medical attention.
- 3 This level is used to indicate a child with a severe history of abuse. This would include a child who has been sexually penetrated on multiple occasions and over an extended period or forced to perform sexual acts on other children or adults. This would also include a child who has been severely physically abused to the point where the child requires serious medical attention (e.g., hospitalization). This level would also indicate a child who has experienced extreme neglect (e.g., severe malnutrition, starvation).

Sexual Development

- 0 This level indicates a child engaging in age appropriate sexual activity. There is no evidence of disrupted sexual development.
- 1 This level indicates a mild disruption in sexual development. This might include some sexually inappropriate activity for the child's developmental stage. An adolescent who is experiencing distress from homosexual urges or impulses might be rated here.
- 2 This level indicates a moderate disruption in sexual development. This could include over-sexualized behavior or an absence of any sexual interest in an adolescent.
- 3 This level indicates a severe disruption in sexual development. This could include grossly inappropriate sexual behavior for age, including sexual aggression. Multiple older partners might be rated here.

Learning Disability/Developmental Delay

- 0 This level indicates a child with no evidence of any learning disabilities or developmental delay.
- 1 This level indicates a child with a mild to moderate learning disability that is likely to make academic achievement more challenging but is not severe enough to require a special school environment. Child's IQ is expected to be greater than 85.
- 2 This level indicates a child with a severe learning disability or a developmental disability that would require a special education environment in order for the child to learn. Child's IQ would be expected to be between 70 and 85.
- 3 This level indicates a child with a profound developmental disability that likely seriously limits the child's academic development. Child's has an IQ of less than 70.

SYSTEM FACTORS

Caregiver Ability to Provide Supervision. This rating should be based on the caregiver's ability to manage behavior and set appropriate limits

- 0 This rating is used to indicate a caregiver circumstance in which supervision and monitoring is appropriate and well-functioning.
- 1 This level indicates a caregiver circumstance in which supervision is generally adequate but inconsistent. This may include a placement in which one member is capable of appropriate monitoring and supervision but others are not capable or not consistently available.
- 2 This level indicates a caregiver circumstance in which supervision and monitoring are very inconsistent and frequently absent.
- 3 This level indicates a caregiver circumstance in which appropriate supervision and monitoring are nearly always absent or inappropriate.

Caregiver Motivation for Change

- 0 This rating is used to indicate a caregiver that is motivated to make changes necessary to solve present problems. This would also include a placement that is actively involved in child's treatment or treatment planning.
- 1 This level indicates a caregiver circumstance in which at least one member is motivated for change. Other members are ambivalent or uninterested. This would also include some evidence of noncompliance with treatment recommendations for child.
- 2 This rating is used to indicate a circumstance in which the caregiver is not motivated to make changes but who is not actively resistant to change. This would also included a placement in which there is disagreement about making changes or moderate noncompliance with child's treatment recommendations.
- 3 This level indicates a caregiver that is resistant to making any changes necessary to solve present problems. This would included severe noncompliance or disruptive involvement with child's treatment. This level would be used for a caregiver who has signed a 14 day notice.

Caregiver Knowledge of Child. This rating should be based on caregiver's knowledge of the specific strengths of the child and any problems experienced by the child and their ability to understand the rationale for the treatment or management of these problems.

- 0 This level indicates that the present caregiver is fully knowledgeable about the child's psychological strengths and weaknesses, talents and limitations.
- 1 This level indicates that the present caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of either the child's psychological condition of his/her talents, skills and assets.
- 2. This level indicates that the caregiver placement does not know or understand the child well and that notable deficits exist in the placement's ability to relate to the child's problems and strengths.
- 3 This level indicates that the present caregiver has a significant problem in understanding the child's current condition. The placement is unable to cope with the child given his/her status at the time, not because of the needs of the child, but because the placement personnel do not understand or accept the situation.

Placement Safety

- 0 This level indicates that the present placement is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
- 1 This level indicates that the present placement environment presents some mild risk of continued neglect, exposure to undesirable environments (e.g., drug use, gangs, etc.) but that no immediate risk is present.
- 2 This level indicates that the present placement environment presents moderate levels of risk to the child including such things as the risk of additional neglect or abuse or exposure to individuals who could harm the child.
- 3 This level indicates that the present placement environment presents a significant risk to the well-being of the child. Risk of neglect or abuse is eminent and immediate. Individuals in the environment offer the potential of significantly harming the child.

Community Capacity for WRAP Services. The definition of community includes the specific placement.

- 0 Community demonstrates ability to involve WRAP services (such as respite, home-based services, etc.) To assist in maintaining the child in the placement given the child's current symptomatology, behavior, and risk. Community and placement may be enthusiastic about these services.
- 1 Community demonstrates some ability or potential to involve WRAP services to assist in maintaining the child in the placement. Community and/or placement may not be enthusiastic, but demonstrates a willingness to try to implement service package.
- 2 Community has limited ability to involve WRAP services in maintaining the child in the placement. Community may lack some necessary services, or these services may be of inadequate quality or the placement may be notably ambivalent about maintaining the child in the current placement.
- 3 Community service providers have no capacity to work with placement (or vice versa) to implement WRAP services. This may be due to the absence of service options, motivation on the part of either the placement or community service providers, knowledge and/or skills.

Multi-System Needs

- 0 This level indicates a child who is involved only with the mental health service system or solely with one system. He/she does not have special needs that must be addressed within other service sectors (e.g., special education, criminal justice).
- 1 This level indicates a child who needs to be involved in special services with one other service system outside of the mental health service system. This would include children with serious medical problems, special education needs, criminal justice involvement, or any additional resource use.
- 2 This level indicates a child with multiple service needs being addressed by agencies that are working together towards complementary goals.
- 3 This level indicates a child with multiple service needs. Agencies have competing goals for the child/adolescent or are uninvolved or refuse to be involved.

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APPENDIX B

Individual Satisfaction Survey Comments

FY05 SASS Parent Comments **July, 2005**

**** All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed. Missing numbers indicate surveys with no comments. ****

Parent #1

We haven't had a psychiatric appointment after 3 weeks and his meds are running out.

Parent #3

The follow up for extra help is in the making.

Parent #5

I wish they would consider the options I requested and I think it's great that they are able to come to our home and to her school.

Parent #6

I think this program is a wonderful service. It saved my son's life, I don't know what would have happened if this wasn't available to us. I can't say enough about this program. Thank you! This is one child you have saved! You all have made a difference in our lives.

Parent #8

I believe they did everything they could to help my granddaughter in her crisis. They also got help for myself. They also keep in touch with us. They also helped get her the right meds to help her continue on getting better. Thank you.

Parent #14

You gave direct and honest observations and gave good advice on what to do to help.

Parent #15

His counselor is great and comes to the house and sees my son once a week and at school one day a week this program is a very good one I think the steps the staff takes.

Parent #17

A child in need of treatment outside the house. Besides the counselor is not fair when it comes to public aid.

Parent #21

I think this is an excellent program. My child was in a crisis and needed hospitalized but we had used the insurance for 2004. My only complaint is that we were told that all mental health services would be paid by the Medicaid card. This has not been the case. We are being billed and re-billed daily. Public aide is not paying for the SASS services. This has cause a huge amount of stress in our family.

Parent #22

Nothing needs to change. I like my SASS worker.

Parent #23

I liked how we talked about things and how I could talk about things that bother me.

Parent #24

I think seeing the caseworker has made a big difference in my son life he used to see another caseworker but since she is not as friendly as the current caseworker so I didn't click with her nor did my son but when she came along it took some time but she is awesome.

Parent #25

I thought SASS was an excellent resource for my children.

Parent #27

More family consuling.

One on one is fairly good.

There should be more normal and active activities

Parenting classes needed and anger management for the family.

Parent #33

Caseworker has been wonderful and encouraging. She is a great listener and worker.

Parent #35

Have not had services very long to answer this question to the fullest as me in a few months or weeks and I could give you a better opion. The caseworker is great she has a wonderful personatiy. I lak her and my son dose to.

Parent #37

I wouldn't suggest anything, I and my daughter have had a excellent experience so far with SASS. Thank you.

Parent #40

While SASS services contracted with [agency] were good, services provided made little impact on child's behavior. Since our SASS services are now contracted with [second agency], we have received very little help. This survey reflects services through [second agency].

Parent #44

The counseling was an excellent expiriance for both parent and child.

Parent #45

Helped me with my depression and gave very good treatment.

Parent #46

More staffed hours per client.

Parent #47

The first worker was very poor didn't keep appt. or was late and no contact with me after first visit and then I had to request another worker.

Parent #50

Caseworker was excellent. She went above and beyond to help our family. She is a great asset to SASS.

Parent #51

Don't leave children in safe room by themselves try talking to them first.

Parent #58

For someone who is autistic and really needs looked after you need a different program. It didn't last one week after home. We took back and they refused to take him back. His aunt and school has helped him more than anyone or the stay in [agency]. No recommended for autistic and the doctor refused to take the case over their. So that didn't help us. He is back on the Zoloft and the new meds we started him on.

Parent #59

The SASS program should not be taken away from a child who feels comfortable with the worker if she is not getting the same out of a therapist.

Parent #60

This county is in need of more services and programs to help children with mental health issues.

Parent #61

Things were really crazy with my whole family and they helped get him to [agency] but then they did not help me get him back home as promised.

Parent #62

Horrible! Terrible! Awful! Stressful! The whole program should be abolished. She hardly ever "had time" to see me. She was completely unorganized and had no plans or good advice. All of the SASS people yelled at us and were very rude. I decided to not continue seeing her because trying to ever make an appointment was very stressful and did not help. The SASS program is much more harm than good for me and I hated it! Shape up! I would never recommend this program even to my worst enemy.

Parent #64

That when calling in for follow-up they didn't give you the run around and they have the correct procedures in place. Also calling you back in a timely fashion. They called me back 3 weeks later after giving me the run around to call this number and that number.

Parent #65

I have had an overall excellent experience with the SASS program. There has been a complete turn around in my child and her behavior towards others. If it was not for this program I don not know where we would be today.

Parent #66

I was waiting for a month and a half for services. Put on waiting list until I called a hotline and they realized I was eligible for services right away. I had called in Dec. the hotline was told turned down. Don't remember that also need services more than once a week. Worker very good. Just not enough time.

Parent #69

To improve: when dealing with ADHD child report to parent discussion. Follow up at school, home, etc. Keep SASS word or call to cancel appointments.

Parent #71

I have not actually got (SASS) started with the SASS after care yet, so some do not apply.

Parent #72

More communication with parent. Explain more about procedures systems. Help other family members try to deal with what is going on. Support groups for children/ adolescents in home area.

Parent #73

I would have the SASS representative explain what SASS is and what they do and the services they provide. Until now I did not know what services they provide or who to call to get that information. Our family was in a crisis and the gentleman who did the screening made me feel very comfortable and secure. He was very caring Please tell him thank you.

Parent #75

None and the one on file.

Parent #76

Wish we could have caseworker longer than 3 months. She is excellent.

Parent #79

Several times I was on hold for too long. For SASS to return my calls took forever. Our caseworker was exceptionally good to us and was other caseworkers thanks.

Parent #80

Our counselor is excellent w/ our son. The educational therapist was also a big help. Getting psych. evals and other procedures need to move a little quicker.

Parent #82

My child's SASS worker has been a great asset to our family—we've applied for an ICG twice and info and insight she gave was a big help!

Parent #84

Our initial crisis happened just prior to Thanksgiving and so any follow-up was difficult due to the holidays. December wasn't much better and we weren't able to see your doctor until January. If any improvements could be made in this area it would be very helpful. Our SASS worker was very helpful regarding his school. She visited his classroom at least once a week and helped to encourage communication between the school and home.

Parent #85

The SASS program has done me and my family a world of good. It's been like a second chance in being a family. I know things won't change overnight but it's a lot better so I plan on staying with this program until I am totally sure that what's happened in my family will not happen again or at least be able to handle it much better. Thank you all, God bless.

Parent #86

I would have liked to have had more joint sessions—myself, daughter, counselor and some more time with the counselor myself. I felt some issues were not addressed enough. Overall everything was good and my daughter really likes her counselor, she is even continuing counseling although she is no longer in SASS.

Parent #87

My son's first visit to the [agency] was in Jan. 2005. It was three weeks before a SASS counselor contacted me (mom) to start counseling. At that point my son became suicidal and was admitted to the

[agency]. The SASS counselor has been to our home one time. He has not returned or called. There will be no improvement in my son until a man steps in to spend lots of time with him.

Parent #89

Just having someone there that understands what we are going through was satisfying. Our SASS worker's attitude and willingness to help is great.

Parent #94

SASS worker was over loaded with cases and had to cancel appointments often. They need to clear schedule for those meetings.

Parent #95

Evaluation states child is suicidal—no one addressed this on anything but a surface level. What are the causes—how can we help understand their feelings?? Where are the services mentioned at the intake?

1. Mended Hearts

2. Montors...etc etc

Parent #96

Group meeting once a month or every other month (so the children can see that they are not alone in their crisis). Rewards for taking their meds consistently (rewards like a note of praise, coupon from McDonalds for a pop, a free pass to the dollar movie in North Town, etc).

Parent #103

So far there's nothing to improve; everyone is doing good; this system is doing a job, something is better than nothing, etc. Thanks "SASS" continue to do more

Parent #110

I prayed for help. And our caseworker came into our lives like an angel. She really has it together I can talk to her any time. She has helped with my child more than anyone has. My child likes her a lot. We are deeply going to miss her. I will feel lost with out her. She means a great deal to all of us. She is excellent and I'm not just writing this I mean it. Hold on to our caseworker you don't need to lose her you'll be lost without her.

Parent #112

I feel they were all very concerned about my daughter and my feelings as well. We are still into the 3 month session, but she seems to be improving.

Parent #117

To be more involved than what they are. My son has seen his SASS worker only twice in the whole month his was home. His care plan called for 3 times a week also to follow through with everything they say to him. For instance my son was promised a respite worker 4 months ago and he still hasn't got one.

Parent #118

People who care. I feel very comfortable with the home visits, they help both of us. This is a wonderful support system for us parents and children. I appreciate these home visits. The more people involved the better for us all. PS It means a lot to have someone who cares I have a very nice worker. Thank you.

Parent #119

Everything has been great!

Parent #120

My child's attitude and behavior hasn't improved but it is not the fault of SASS worker. Sass worker has worked diligently and even stopped by to just check on my daughter. My daughter is now on meds for her behavior.

Parent #122

More feedback between the counselor and parents are needed. Services are good and the counselor was great! Initial response was very good. Child was returned to biological mother after 3 months so no follow-up care was scheduled although I feel more counseling was needed. Counselor was going to contact facilities child was moving to.

Parent #123

Need more service (workers) 1st time around poor service would not work with us had to fire her. 2nd time very good. It would be nice if worker had more time to spend with my child.

Parent #124

The caseworker was extremely rude and impatient. She indicated that I, the parent, had no say so in where my child was hospitalized—maybe she needed better training or more education. SASS workers should not be rude and condescending like that.

Parent #128

Feel it helped some, but need more programs in age group. Child is now in a special needs school after multiple times trying to find programs and needs in the child's category.

Parent #130

Counselor was very good and helped our son.

Parent #131

I think SASS's service is excellent and we are very thankful with the SASS worker because she is very professional and helps my son a lot.

Parent #132

What SASS sees as important to maintain stability in a home setting (of 4 years) [agency] does not! She was here to see [agency] looks at the numbers not the child. She is not given the ability after all her work with the child going to school as well as visits at home with the parents and the child—seeing the siblings all the interaction not to mention her unique ability and many years of dedication to the children and families giving her insight only experience can. In my eyes she is not given the liberty to call the shots. You don't seem to realize what you have in her. She is so very dedicated to the children and their needs. Take another look and listen it would benefit all. [agency] told me after a meeting with them that SASS cannot provide what they see as the most important "factor" to make it all work together! All families and needs are different and most don't fit into a box.

Parent #133

Ninguno pues todos los servicios son muy Buenos todos pues cuando uno llama de inmediato atienden a las personas que necesitamos de los servicios.
Nothing, well, all the services are very good. Well, when someone calls they attend you right away.

Parent #137

[Child] has done a big turn around at home and at school. That's wonderful I'm very pleased with his grades. Thank You !!

Parent #139

More follow-up, help getting appts that are needed. We are having problems getting things done to send for ICG. Maybe in the future we can find a way to help families in crisis.

Parent #142

My son's case manager and social worker has been great, my son respects and adores her, she has always gone out of her way to help us whenever needed. She should be recognized for all of her excellent and outstanding work with children.

Parent #144

More parent & SASS follow-ups with each session. Once caseworker went to my son's school and counseled I did not receive any reports until the caseworker was done.

Parent #146

The behavior modification techniques are good their response to crisis was good too.

Parent #148

This child has had another crisis while she was using SASS services. This time when she came home she is seeing another counselor. I would have preferred her to stay with the same counselor because she was familiar with the situation. I have not had any contact with the new counselor at all. I think there should be more involvement with the parents/caregiver.

Parent #149

1. Care
2. Overall concern, services helped patient and parent to help with problems

Parent #151

My child would not talk to the SASS worker. The SASS worker has helped me in dealing with the child. Her behavior has improved.

The service is available at all times and I feel that I can call when the need arises.

Parent #156

The good aspects of the SASS program was the fact every worker went above and beyond to make sure other services were made known to me and my family.

Parent #158

I think that the program should be longer and that if they're assigned a certain SASS counselor they should stay with that one, my caseworker has been excellent through this. She needs to be able to spend more time with the kids instead of 90 days.

Parent #161

SASS helped me financially when I was in need. Thanks

My counselor helped me and my family communicate more with each other and learn to express how we feel. She was there to help when my daughter was in crisis and when I heard that she was going to be the worker for my niece I was very happy because I knew she's going to be the one to help her get on the right track.

Parent #164

Hire more workers for the SASS program, you have some good workers and we do not want them to burn out. Our caseworker was a very caring and efficient SASS worker for our son. She made herself available and helped to make sure our son knew he was protected, safe, and loved. She was excellent helping our family.

Parent # 166

Todos los servicios de SASS son muy Buenos, me siento muy satisficha du programa de SASS porque las cosas an mejorado con mi hija, coda vez que [caseworker] viene ala casa a platicar con mi hija y con migo mi hija se comporta miejor.

Gracias por su ayoda y por preocuparse por el bien star de nosotros.

All the services provided by SASS are very Good, I feel very much satisfied by the SASS program because of all the things I see have improved with my daughter.

Every time [caseworker] comes to the house to talk to my daughter and to me, my daughter behaves better.

Thank you for your help and caring for our well-being.

Parent #167

Appointments could be made by an office personnel instead of the case worker therefore could be made more quickly.

Parent #168

[Child]'s counsler wasn't responding to [child]'s needs or returning phone calls or anything.

Parent #170

They need to remember that children are not going to act out for them like they do for the parent. Need to spend more time with the children then 5 min they are not going to know anything.

Parent #173

We feel that because we live in a Rural are – (1hr from the SASS office) that the workers did not want to make the effort to drive to our home. Telephone response to our calls was very poor – left messages multiple times and it took days to weeks for a response. It took almost one month for the first appointment to be made. Workers need to realize that not everyone needing help lives within the city-town their office is in. When specifically request a male counselor for a male teenager in crisis – more effort needs to be made to honor that request.

Parent #174

I was very disappointed when [caseworker]'s services were over. She was excellent!

Parent # 175

All are good, wouldn't change anything.

Parent #176

SASS services are excellent in every aspect. God Bless them! I hope that they get help to move forward so that they help more adolescent stop using drugs. Thank you, SASS!

Parent #179

This service helped me to look at things in another manner instead of always been angry at this child. Try to cope and deal with it.

Parent #184

My experiences with SASS employees have been above average. However, since SASS services are now offered thru [agency] (opposed to [second agency]) our services have been less than ideal. I.E. our SASS worker does not have an office or voice mail for us to contact him. Since I prefer to call the Crisis Line only during a crisis, this has created some contact problems between myself & our SASS worker, [name]. [Name] does a great job and I am sure this is not his fault but I believe [second agency] can do a better job providing "their" part of SASS services. Thank you!

Parent #189

Sass workers should also be made available as case managers for children.

I would like Sass help soon because we are headed for a crisis with summer comming and I also need help applying for SSD for my child. I don't understand all this paper work and these grants I've got to apply for. She needs a plan for this summer. And I need help with the school as well.

Parent #190

There to nosey over all

Say out of peoples business.

And help the parent and the child to get along better.

Parent #192

Need more counselors because of restrictions on appointment available. Too many people per counselor.

Parent #193

Our SASS worker, [name], was a wonderful person. She was very supportive of us. She was a great help.

Parent #194

Timeliness with which SASS responds is very good. However, the only improvement we can suggest is longer involvement with SASS & child.

Parent #195

To have a follow-up visit in 3 – 6 month's to make sure that everything is O.K. and no problems going on.

Parent #196

[Caseworker] & [second caseworker] were excellent in our case. Our son was hospitalized @ [agency], IL on 2/17/05 & released 4/1/05 The services I received as a parent were excellent. [Second caseworker] & [child] (my son) will spend the rest of this month. Thanks, [parent] 4/4/05

Parent #197

Our SASS worker was wonderful. She was so helpful and her guidance, direction, and suggestions were right "on track" to helping with solutions to our problems. I would highly suggest this wonderful program to anyone in need of these services.

Parent #198

Our work was kind& respectful. The partial hospitalization program we were sent to was not covered financially by the program – we thought it would be. Workers in all areas of the field need to know what's covered and what isn't . (both at SASS & the hospitals)

Parent #202

My child didn't actively receive services until 6 weeks into his 12 week plan. I feel the SASS worker was very helpful and could have been more beneficial with a longer time frame to address issues.

Parent #203

The counselor came every week on time and shows a great sense of really wanting too help. She provides us w/information that's current.

Parent # 205

I would like them to have a tutoring program to help the children when they aren't getting grades or are having problems with a subject.

Parent # 206

Every experience my child and I has had with SASS has been great. I have no regrets or disappointments with their services. SASS has brought me and my family even closer than we already were. SASS has also given us several ways to look at situations and how to come to solutions we all could agree on and deal with our decisions.

Parent # 207

The SASS program is an asset to both the patient & his/her family. Our family couldn't have gotten through this crisis without the help of our SASS counselor. [Caseworker] was essential in our efforts to

bridge communications with our son again. She helped us all by listening to our individual concerns & helping us to see how to more effectively relate to each other & realize one another's feelings & concerns. The only thing that we found difficult was the time between when we hospitalized our son, he was released, & we were informed about the SASS program. It would have been helpful to have the SASS program explained to us while he was in the hospital – so we knew we would have some guidance when he got home & would have been less stressed about how we would all deal with him once he comes home. It would have helped us to feel more prepared to deal with the situation – if we'd known that we wouldn't be alone in our efforts.

Parent # 210

We like our SASS counselor. She seems understanding, caring, competent. However – the services our family received have been inconsistent. The counselor canceled a lot in the beginning to meet with us as a family. Our child sees her at school but often complains that she doesn't get to see her often enough. I feel neither our child, nor us have had much interaction with the counselor. I am rather disappointed because the services haven't been of much help when we've needed it. I feel there needs to be more communication & time. Spent on making sure appointments are kept and that the time we are together is spent in a fashion that a goal is achieved at each session. It's been very confusing frustrating & disappointing because we really haven't gotten the structured support we need.

Parent # 213

Your worker trying real hard. [Child], grandchild, needs to have better feelings toward family, has improved some. Dad has given him wrong ideas and still is, can't tell truth yet.

Parent # 215

Everything that was supposed to be done was done but, it wasn't followed through or checked upon regularly. The workers need to spend more time with all parties in the family together to communicate, make suggestions, make plans, and I believe when a goal is agreed upon the worker, parent and child need to be together and the worker should help set up whatever needed to reach those goals. As well as explaining them to the child more extensively my daughter really enjoyed spending time with her worker, though and liked the interest from someone else. So thank you.

Parent # 216

SASS is the best that I've seen. They are very kind and care for the entire family. They have an excellent program, thank you for the help.

Parent # 217

If a child is in crisis, he/she shouldn't have to wait until the next morning to be hospitalized because the SASS worker has not made efforts to find a hospital.

Parent # 218

Everyone to know what is going on that is involved in the case. To pass on information.

Parent # 220

[Caseworker] has helped us in so many ways. She helped deal with the death of daughter/sister she even came and did dishes and helped with supper. My son does not normally form a bond with any worker but [child] loves [caseworker] and responds to her. Thanks for sending her to him.

Parent # 222

To be able to sit down in one or two sessions to finish paperwork. So far we've had 6 visits together and still not done.

Parent # 224

Wish the assigned counselor could spend more than 90 days with him. Seemed like she was just reaching the problem.

Parent # 230

SASS people knowing daughter & work at that. It would have been very difficult without their help.

Parent # 233

Address spirituality

Parent #237

More intense training of parents to help prevent the child from abusing themselves such as the steps programs. I'm feeling very inadequate at this time.

Parent #239

Our SASS worker didn't stay in touch. When at the office for an appointment with someone other than the SASS worker, we were informed our SASS case was closed. Both my children were promised mentoring in special activities such as karate and horse care. Both of my boys now feel they can't believe anyone in this office. We don't have other options within our rural area and due to our low income I feel as though my boys are to slip through the cracks due to my inability to pay for consistent/good care.

Parent #240

I haven't been with SASS long enough to know much about it. Thanks.

FY05 SASS Agency Administrator Comments

July, 2005

** All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed. Missing numbers indicate surveys with no comments. **

Agency #01

1. Reimbursement timeliness relates to organizational readiness. Our start up for billing was a learning curve al new to us. The cost of billing production is still too high. We are just now implementing electronic billing. The business training is needed to decrease our production costs while also increasing our service units. The increased consumer access to SASS is evidenced by the volume increase.
2. Payment rates do not cover infrastructure costs of maintaining 24/7 on-call services.
3. We need to develop stabilization criteria that cross all providers.
4. We need to define the SASS MODEL as a system of care based on evidence-based practices.

Agency #04

1. More children and families are being reached.
2. The rate structure (or Medicaid billing model) does not support CAASP principles.
3. There is no mechanism to pay for psychiatric services.
4. The eligibility process hampers service delivery.
5. Extention (SOC) process is cumbersome and problem prone.

Agency #05

The quality of technical support for billing needs to be vastly improved. Statistics on deflections and hospitalizations of high risk and low risk kids are meaningless unless you examine the growing recidivism and re-hospitalization rates. Before the new contract we could keep clients long enough to actually stabilize them. Now our SASS program has become a revolving door. I unfortunately do not see anything excellent about the program design.

Agency #07

Payment and rejection rates have been time consuming for administrative personnel and is a key variable in evaluating the costs of the program.

Transportation issues for clients and SASS providers in rural areas need to be taken into account as inpatient hospitalizations are over 50 miles away. We have not experienced recent difficulties coordinating care with CARES. There were problems on who would call them. This has not come up over the past few months, however.

Agency #08

The subcontract creates up to 1 hour delays in referral time. CARES hotline staff at times have been rude and inappropriate with our staff.

The CARES system has in many ways made it more difficult for clients to obtain needed hospitalizations or services due to CARES staff declining eligibility on many various levels.

The CARES system and the need to constantly enter info into the HIS system is time-consuming and detracts from case management services that could be offered to the clients.

Clients who truly need SASS extensions past 3 months are not being approved for them.

Insistence that SASS after hours screenings take place on site places staff at potential risk of harm in some instances particularly when going in the dark to hostile environments at the home.

Agency #10

Look at 90 day eligibility, needs to be based on clinical need, not a flat # of days.

Reimbursement problems, difficulty getting billing system up and going.

Agency #11

Problematic inconsistencies between SASS trainings and CARES information and direction.

Generally confusing and unclear

Inefficiency w/ use of CARES

SASS services are in no way different from regular therapy services provided.

Business model detracts from individualized assessment and treatment.

Agency #12

Early projections indicate than our SASS Program will be operating in a deficit. Medicaid rates don't cover our costs. Additional variable is the extreme rural nature of our area and the non-reimbursable expenses of travel expenses that the rates don't adequately offset. Another factor is the additional administrative and business expense costs to SASS associated with the new re design.

Lastly, a key factor is the lack of infrastructure to address [clients? Note: not able to read this word – it's a reasonable guess] within SASS who need follow up care after SASS. Extensions beyond 90 days of SASS are difficult to get, and the step down of services from these seriously disturbed youth are limited and not adequately funded.

Agency #14

I am attaching an excerpt of a letter I received that sums up the issues that providers have with SASS.

[Note: there was no attachment to the survey or in the envelope with the survey.]

Agency #15

The transfer process and assignment of eligibility and assignment of provider ID numbers has been extremely time consuming and problematic. Approval should be granted for the "SASS System" as opposed to individual providers. Additionally, 90 days is an arbitrary number. Each family is unique and may need more or less to stabilize. This creates a problem when extensions are denied or eligibility remains open and clients are not actively in services.

Agency #16

As a clinician, I find it difficult to deny services based on income/insurance coverage. It is disappointing (and seems unfair) to have to deny SASS services to hard working individuals who are trying to support and take care of their families.

Agency #17

SASS services are by their nature expensive to provide yet the fee structure is such that my center is losing money. At this rate we may have to stop providing the service.

Agency #18

Many of the staff involved in this initiative have been very helpful, particularly [name] and [name]. However, responsiveness to questions has not been a problem; getting consistent and accurate information is the issue.

As of this date, our agency has yet to be paid for an ICG cases despite a number of discussions, meetings, etc.

Reimbursement is generally cumbersome and not timely. It is unclear for what services we are being paid when we receive a payment. The notion of one payment for these services is critical but the three agencies have not streamlined their procedures sufficiently to make the process 'provider friendly'

We do, however, believe in the initiative and feel that children and families are benefiting; however, an issue of cash flow is developing which only serves to cost our agency more money in borrowing to make necessary payments.

We do, also, appreciate this survey and the attempts of the agencies to work out these issues. If we can be of any help please feel free to contact me: [name, agency]

Agency #19

[name] at [agency] = excellent

Involvement of provider agencies in subcommittee = excellent

[name, agency] = excellent

[name]: - [agency] = excellent

- Medicaid billing does not cover all the case work that gets done and added on requirements. For example, faxing C-SPIs, HSOFI computer entries, traveling an hour for a 48 hr contact to see someone who doesn't have a phone and then isn't home (=2 hrs lost time). Off site services are not compensated for high enough. A lot of unbillable time goes into transfers which are a valuable piece of SASS services.
- Get us copies of the federal Medicaid guidelines and our state waivers!!

Agency #20

- Have local hospitals call the SASS provider directly and then have the SASS providers report electronically in the disposition of the case eliminating the cost of the CARES line which is nothing more than an unnecessary nuisance and an extra layer of bureaucracy down state.
- Get an electronic billing system in place.
- Do not attempt anything like this again with pilot testing. This has been a dismal failure.
- Compensate agencies for administrative and travel costs for teleconferences and meetings.

Agency #21

- Process of sending CSPI to Northwestern is slightly problematic.
- Cooperation from area hospitals in getting discharge summaries for SASS kids also problematic.

Agency #22

High screenings = low direct service post screening

Other issues have been discussed with state: why are you asking for more of the same?

Agency #24

There is a major loss of services by unfunded families using this program. Medicaid clients who present at an emergency room have this expense covered, unfunded families do not. The same issue applies for use of an ambulance.

I think the benefit of monitoring 18-21 yr olds who have Medicaid is questionable, especially since unfunded clients of the same age do not have these benefits. The agencies in this area who provide adult DMH services are not the same as those providing C&A DMH services.

Agency #25

Problem:

1. There is a discontinuity of business and clinical principles within this program. CASSP principles and best practice support extensive community and home-based services, however fees do not support these activities.

Suggestion:

1. Develop other means of financial support (e.g. capacity grants; administrative budget allotments) to offset costs incurred in providing established and empirically supported best practices—travel and on-call times.

Problem:

2. The amount of management and administrative support for billing preparation, submission, as well as corrections and **re-corrections** needed due to the state's inadequate and ill-prepared billing system. Also, training and supervision related to the provision of highly specialized intensive services among the highest-risk and most vulnerable of populations.

Suggestion:

2. Develop other means of financial support (e.g. capacity grants; administrative budget allotments) to offset costs incurred for administrative expenses related to the implementation of the SASS program and responding to continuous delays, changes and state-legal procedural ambiguities. And, of course, to support those activities that support staff to ensure high quality care (e.g. training, supervision, staff retention.)

Problem:

3. Inadequate planning for the continuation of much needed intensive services beyond the anticipated stabilization period of 90 days. Insufficient community-based treatment programs equipped to meet the needs of this population.

Suggestion:

3. Increased funding for other community-based programs to provide continued treatment post-SASS eligibility.

Problem:

4. Gross inadequacies in planning this change. Veteran SASS agencies with proven success and knowledge were not consulted in preparation for this expansive change. Valuable insight, had it been solicited, would have identified problems **before** implementation.

Suggestion:

4. Increased validity and influence of existing stakeholder groups. Also, more geographically based representation taking into consideration communities' diverse needs, problems and solutions. (E.g. beyond state southern and northern regions.)

Also, it is requested that state department representatives please stop openly referring to this as a learning process—while most of us would agree that it is, it is a reminder of how poorly planned this change was and that the many of the problems we are “learning” could have been, and were previously, known.

Problem:

5. There is insufficient backing or support for SASS providers (and families) in dealing with hospitals when treatment philosophy and recommendations differ.

Suggestion:

5. More substantive training and workgroup activities to promote collaboration between SASS agencies and hospitals as well as more education about parents', clients', families' rights. The creation of Utilization Management protocols to examine treatment discrepancies as well as appropriate service utilization that could be used by both SASS and hospitals. In particular, the scope and limits of EMTALA. (It is acknowledged that SASS providers have the responsibility to attempt these in a grass roots individualized basis, however stronger backing would be beneficial). Perhaps funding for agency staff to coordinate with and educate hospitals as well as schools, juvenile court services and private practitioners.

Problem:

6. **Extensive delays** in answers to much needed questions and solutions to significant problems (e.g. there is still no solution for psychiatric service reimbursement for limited package SASS participants. This issue has been continually raised since July 1—8 1/2 months into this program.)

Suggestion:

6. To begin, do not have state agency representatives simply say, “We are working on it.” **Solve this problem.** Also, have more direct contact with individual SASS agencies to solicit input and other feedback.

Problem:

7. LOS extension approval process seems ambiguous and capricious.

Suggestion:

7. Develop specific, consistent and public criteria that is used to determine and (sic) extension (e.g. Utilization Management?). Also, establish levels of extensions based on needs (e.g. UM?) and approve LOS accordingly—not just 15 or 30 days.

Problem:

8. Management of interagency SASS client transfer is immensely time consuming, and significantly impacts client continuity of care for which little billable revenue can be obtained.

Suggestion:

8. Establish a statewide approval process for clients to receive SASS services from any SASS provider throughout Illinois, not requiring approval via CARES. Similar to Medicaid, once eligible, clients and families can access any Medicaid provider throughout the state easily and quickly.

Problem:

9. Unclear as to what CARES use to determine eligibility into the SASS program. Clarify what the acuity screening measures? Why do they screen at all?

Suggestion:

9. Have SASS determine this – we used to.

Agency #26

W/a fee for service program, more timely turn-around of billing would be beneficial.

Agency #27

- 1) Increase the rates, especially for SASS pre-screening. The current rate of \$319 does not cover the cost of the service --
- 2) CARES should only take the call and route to the appropriate SASS (not do clinical screening on the phone) – SASS should be the one determining appropriateness for crisis stabilization services –
- 3) Extensions should be eliminated (as it exists now). There are children that will need more intensive services for longer time –
- 4) All SASS services should be available to ALL children. Currently, children with temporary RINS do not have access to PHP nor to psychiatric evaluations/med monitoring –

Agency #28

Junk Cares line. 1 800 adds confusion x 100.

Junk extension request, it adds more burden than it is worth. Fix a time and go with it.

Medicaid rates are completely out of line with real world costs, they need adjustment.

Melding DCFS and DMH has been ok but adding IDPA seems to have resulted in the lost the clinical practice/ focus, in preference to practice management (nickel counting). It has added weight without maintaining quality.

Once SASS felt like a partnership, now it feels like a burden.

Agency #29

Elimination of the care line. Functioning billing septon resulting in payment to providers in a timely manner.

FY05 SASS Program Director Comments

July, 2005

** All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed. Missing numbers indicate surveys with no comments. **

Agency #1

Revert to localized access to SASS, eliminating the CARES line.

Increase reimbursement rates or build in capacity funds in order to pay for the 24/7 crisis response staffing burden.

The response time requirement is good, as is the use of the CSPI as an assessment device.

Agency #2

I believe many of the SASS agencies – especially those that were in existence prior to 7/1/04 are doing remarkably well at continuing to provide excellent clinical care – unfortunately it is at the fiscal detriment to the agency. In the recent future something will have to give – clinical care or the SASS program overall will end @ the agency. The state needs to come up w/ a way to pay for psychiatric time for unfunded clients and pay the agency for administrative, travel, paperwork, failed apts, staffing the program. If this does not occur the SASS program @ one agency will end.

Agency #6

Instead of having only 1 SASS agency approved for services ALL SASS should be approved to make the transitions from the SASS who responds to the crisis to the SASS who will follow up with services smoother.

I feel that CARES should allow for some differences of opinion when a child is clearly having behavioral problems which don't always merit a hospitalization and those that are going through emotional problems. Sometimes I wonder why CARES is needed. It seems that instead of saving money we are spending much more. If the system wasn't broken why change it?

Agency #7

Screening @ hospital w/ Dr. order provides opportunity to build rapport w/ family. Even though decision made by Dr, SASS has a role w/ the family by being involved w/ crisis partnering begins early on. We have seen increase in follow through post hosp. because of the relationship. Provide protocol for extensions to providers and allow providers to complete clinical determination for extension. Internal decision w/ supporting documentation submitted to state.

Remove CARES to ensure immediate access to SASS provider. Remove lag time from CARES receiving call and dispatch of SASS Rec: state 88#, automated request to enter child's zip code. Zip code routes call to appropriate SASS pager. Automated attendant requests referral source phone # which appears on pager. SASS responds immediately to referral source. All calls can be monitored/counted through phone line.

Agency #11

In our area, CARES impedes access to care. I'd suggest CARES not always be the 1st one called or used to determine the need for screening.

The reimbursement is too low for the type and volume of services provided. It does not cover the cost of providing the services. The "glitches" and delays in the system are more than problematic for viability.

Agency #12

Benefits

1. All children in IL have an independent evaluator/assessor determining needs or hospitalization when SASS provider is contacted.
2. More hospitals have been opened up to SASS clientele. More sources are available to clients and advocates can make recommendations depending on client's needs.
3. Medicaid clients will have help learning how to stabilize their children's behavior and meet their needs, sometimes without hospitalizations to deal with a recurrent crisis.

Improvement

1. Lead agency is primarily about finance and not clinical services; more focus on clinical aspect of SASS.
2. Policies and procedures need to be thought out, before presentation to SASS providers. The expansion was poorly executed by the lead agency.

Agency #14

Non-billable administrative requirements are at a much higher ratio than other publicly funded mental health programs.

Streamlining technical process is greatly needed.

ICG's inadequate in both technical assistance and agency compensation.

Difficult to provide continuity of care with resource limitations.

Strengths: Standardization of publicly funded crisis services. Far fewer inappropriate psychiatric hospitalizations for DPA youth.

Agency #17

Length of service, 90 days, is arbitrary & often too short

Extensions are too hard to get

The response times in our large geographic area is unreasonable

Increased paperwork and misc. non-reimbursable tasks, e.g., faxing, entry on web sites, SASS transfers

CSPIs are not applicable to young adults

CSPIs "get lost" in the faxing process

Increased program supervision time/ monitoring for compliance, finding "lost" data

Billing process very time consuming

CARES screening makes for MORE complicated referral process from the community point of view

We are serving more DPA clients but other children with limited insurance coverage are NOT being served. There are not alternative health care resources for them.

There is a certain subset of SASS clients who do not transition to general out patient and get no service unless in SASS

Travel time in our area is extensive and not reimbursed

Increased demands on SASS staff to do more ICG work.

Out patient staff are having a hard time responding to increase f/u for SASS clients being stepped down

Agency #18

Mandatory DPA screens + Fee-for-Service + CARES Acuity Screen = SASS RIP

The clinical integrity of SASS services has been decimated.

- Home LAN SASS agents should screen residents of their LANs. Prescreenings are the big ticket items in DPA billing so agencies doing the most screenings are more able to remain viable. Screenings that Metro FS would normally do are usurped by marketing efforts that

take clients directly to freestanding psych facilities into other SASS agent's LANs. As a result, the projected number of prescreenings are way down.

- CARES Acuity phone screening should not upstage the face-to-face clinical prescreening. Fewer clients should be screened out or phone screen should be eliminated.
- Community-based emergency response services should not be on a fee-for-service basis. Office-based, discrete clinical sessions are ideal for FFS. Not psychiatric paramedic work.

Agency #20

The screening tool is good, the short period a child is served in SASS Program is very poor, because we find it difficult to stabilize a severe Emotional Disorder child in 3 months. A six months extension would be somewhat appropriate.

Agency #22

Case mgt. can provide as much as S.A.S.S. program – Due to all the screenings difficult to provide adequate services to those certified in SASS. Do not have the financial means to continue to hire staff.

Agency #24

Lack of inservice training and answers to questions that arise.

Parents to have a better understanding of their need to participate in SASS services.

Coordination of services is good but further refinement is necessary.

Agency #27

Extension requests should be considered even if child has not returned to the hospital.

Providers should have the authority to end eligibility if client refuses services rather than keeping client open in the state system for 90 days under that provider. (Recommendation made at SASS meeting.)

SASS workers spend a lot of time in transportation which is not billable. This needs to be compensated some way.

Agency #28

-- The ability to see children and families as often as needed remains the best part of the program as based on original design.

-- We would prefer to respond to children and families in crisis immediately and get information to CARES later. CARES has passed through many inappropriate referrals and I believe this may be due to phone screen versus face to face.

-- We continue to get e-mails about changes to the program design/protocol on a fairly regular basis. I'm not sure how to correct since this should have been addressed prior to 7/1/04. Consistency would ease confusion.

-- Despite a rocky initial referral process, we are able to continue with children & families who are willing to participate and achieve good outcomes.

-- The process of entering info in HIS, faxing C-SPI's, billing, etc remains very cumbersome. Lessening the reporting burden somehow would be most helpful and would allow us to focus more fully on clinical treatment.

Agency #30

Re-evaluate the acuity scale.

Agency #32

Assistance with billing would be greatly appreciated – we get different answers from every person we talk to and therefore figuring out the billing system has been a nightmare – not to mention that we are losing money because we aren't getting paid.

Prior approvals have been a huge problem – since we have more than one provider ID# the CARES line continually assigns the youth to the wrong number and therefore it takes a lot of time to get fixed – as well as billing gets rejected.

Having to rely on other agencies to call CARES and make referrals is not working – there needs to be some sort of penalty for those agencies that are not following through – it wastes a lot of our time having to call them over and over until they do it – not to mention that the kids are not getting services if we aren't authorized.

Providing services has been the easiest part of SASS – navigating the Medicaid system is a different story, which isn't as positive.

FY05 SASS Hospitals Comments

August, 2005

**** This survey was a phone survey. All comments are printed as they were transcribed by the surveyor but with any identifying information removed. ****

Psychiatric Hospitals

1) Would you describe what you like about the CARES line?

The line is nice for people who come in with no funding. We used to have to go through a longer process with DHS for admission of these patients. Now they are given a temporary public aid number by CARES, which facilitates the process.

The workers are polite, easy to reach, and accommodating.

There is nothing that I like about the CARES line.

They are fairly timely in their response to our call and their dispatch of a SASS worker.

The process allows us to receive payment much more quickly than in the past.

The workers are generally very nice and helpful.

The staff is very friendly. I believe that they advocate in favor of patients.

My experiences with the CARES line have been pretty positive.

We have had no major problems with CARES. They have always sent someone out when we have called.

2) Would you describe what you dislike about the CARES line?

The line is generally an extra step in the process.

When they gather information about a given patient, the process is very lengthy. Also, in the past they have forgotten to call SASS after finishing with the hospital.

Sometimes the CARES workers seem very confused. They are inconsistent in the number of questions that they ask. It can take a long time to get ahold of them.

The CARES workers are not clinicians and don't have the clinical judgment skills necessary to make the decisions that they make.

When a patient presents and needs to be admitted it becomes very cumbersome to get the patient through the process. There are too many agencies involved in the process. If cases are not monitored very closely on a day-to-day basis, there is a very real possibility of an error being made that will make it difficult to receive payment.

At the hospital, we are seeing patients and doing face-to-face evaluations. The CARES workers are doing acuity screenings over the phone, yet their screenings do not always agree with our face-to-face assessments, which are more valid. Also, there is occasionally confusion. For example, if someone has a duplicate recipient ID number, it takes significant time for CARES to get back to us regarding which number to use.

There is nothing that I dislike about the CARES line. (3 respondents)

3) Do you have any suggestions for the improvement of the CARES line?

The CARES worker does not always give his or her name during the call. This makes it difficult to clear up error made by the CARES line with H.S.I. CARES workers should give their names at the outset of calls.

I think that the line is repetitive. When information is given to CARES, SASS calls back and asks the same questions. Also, there have been occasions where either CARES or SASS has incorrectly recorded information we have given them, such as misspelling names. Finally, I believe that CARES should ask about sexually inappropriate behavior, as that is a relevant risk factor.

There needs to be more consistency in terms of what information they need from the hospitals.

We have some difficulties with the competence of the workers after 3 P.M. specifically.

The people doing the initial assessments need to be qualified to make those assessments.

The acuity screen should either be dropped or modified so that it is more of a service screen. That is, if a clinical professional determines that the case merits a SASS worker, we should receive an automatic “yes” from CARES.

They should aim for shorter wait times on hold.

I have no suggestions. (3 respondents)

4) Would you describe what you like about the SASS program?

The SASS program always provides a pre-admission screening process that is often very useful. It is helpful to have some observation of a child in a less restricted area than the hospital. With private patients, the only such observation we receive is from parents.

The follow-up services they have set up for the time after inpatient care are excellent if done correctly.

The workers are thorough and hands-on.

The workers in our home agency are excellent. They are great clinically, easy to work with, and have sound clinical judgment.

When patients leave this facility, they are not just leaving empty-handed. We value the SASS program’s post-discharge services.

If we decide to deflect, we know that SASS will be involved with the patient for 90 days. They provide good services for patients who are not necessarily in need of hospitalization. Also, they provide accessibility for people without funding.

At times they are easy to work with.

I believe that the program is very positive. Patients need someone to follow through with aftercare, and if there were no SASS program, I would say probably less than half would follow through.

There is nothing in particular that I like about the SASS program.

5) Would you describe what you dislike about the SASS program?

We often deal with SASS agencies out of our geographic area, and for these it is often difficult to find out who the local worker on a give case is.

Regarding crisis assessment, it is redundant with regard to the assessment done in the hospital. Also, there is also often a lapse of time between when a patient is released and when follow-up care is initiated; during this lapse, patients are often readmitted to the hospital.

There is nothing that I dislike about the SASS program. (2 respondents)

It is difficult at times to get the SASS workers to cooperate with the hospital. They can be very contentious.

Transfers can be very confusing. No one really know who will receive the transfer, and if there is a transfer, it often gets lost. Also, patients who are deflected are often not getting there services in time.

This is causing patients to return to the hospital. Finally, we are still having problems with SASS not checking the discharge-planning box, particularly when a transfer is involved.

I believe that they minimize patient actions. Recently, I had them recommend deflection on a child who attempted suicide, saying that he was simply angry at the time. They put patients at risk and do them a huge disservice when they attempt to deny admission despite hospital requests to the contrary. We are forced to override their decisions about 75% of the time. I don not believe that child safety in their #1 priority. Deflecting patients and satisfying parents are their top priorities.

I don’t see certain agencies following through during hospitalization.

Overall, the program is very redundant on the admissions side: there are too many levels of assessment occurring. Also, there is the potential for conflict of interest with the program. There are SASS workers who are working part-time for a SASS agency and part-time in hospital admissions departments. This is unacceptable if an objective, unbiased view is desired.

6) Do you have any suggestions for the improvement of the SASS program?

The program is redundant and takes too long. Often they ask questions over the phone which could be answered at the hospital despite the fact that they are coming into the hospital anyway.

There seem to be inconsistencies across jurisdictions. For example, one agency with which we work has a very thorough checklist, while another has only a one-page checklist.

Everyone needs to be on the same page. For example, we have had a number of miscommunications with SASS agencies over whether or not patients age 18-21 need to be SASSed. We have been given conflicting answers by the agencies. The protocol needs to be laid out clearly for everyone.

The State should approve extra funds for unfunded 18-20 year olds. Also, the various SASS agencies should have a uniform screening tool. Some currently have a very thorough screening tool, while others have only a page.

They need to understand that events such as suicide attempts always need to be taken seriously.

They should possibly hire more workers; a lot of their workers seemed to be overloaded with casework.

The redundancy needs to be eliminated. Also, communication between SASS agencies needs to improve.

During transfers, there have been breakdowns in communication. The second agency has not gotten the relevant information in a timely fashion, buttons have not been clicked, and we have not gotten paid.

Finally, the benefits of temporary REN numbers do not currently include physician billing. There is no compensation for physicians and no compensation for patients to be entered into partial hospitalization under the current system.

I have no suggestions.(4 respondents)

7) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the children and families you serve? If so, in what way?

The CARES process now has to be explained to parents who call into the hospital, and they often find it very confusing. Sometimes they are left with the impression that we don't want to admit their child, when in fact they are simply required to go through the CARES process.

Yes; the new system prolongs the process for them. Also, parents say that they sometimes meet with a SASS worker once and never hear back. Follow-up is not always happening.

There is now a higher rate of deflection, and after care has improved now that it is no longer solely in the hands of the parents.

In the past, we were able to accommodate patients very quickly. Now, patients are left waiting for hours while we go through the proper channels. This is very difficult for the parents, and it causes the children to escalate.

Families are saying that their SASS workers are more involved. Also, we are able to get more information regarding family dynamics.

Yes. From a continuity of care standpoint, patients have been linked more effectively to outpatient services.

The changes have had no effect on the children and families that we serve.

8) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the hospital's clinical operations? If so, in what way?

The increased number of eligible patients has added to the overall paperwork.

The kids we admit now are more acute, and we have had increased staffing, which is an improvement.

Doctors have to be more responsible now in terms of staffing; they must have a set schedule in place. It is nice to have an extra team player now, someone who may have different ideas and more resources available.

Yes. The changes have bogged down the front end of admissions. We are no longer able to admit patients in a timely fashion.

The changes have had no effect on clinical operations. (3 respondents)

General Hospitals with Child and Adolescent Inpatient Psychiatry Units

1) Would you describe what you like about the CARES line?

The line succeeds in acting as a facilitator between the hospital and SASS.

Some of the workers are very courteous.

The workers are courteous and knowledgeable, and they are always aware of the appropriate SASS contact in a given area.

The access to confirmation of current Medicaid status is one of the few good elements of the program.

The workers are very helpful, and their screening methods are straight- forward.

Things have definitely improved since November. There were some growing pains at first, but now those have been resolved and I am satisfied with the program. The ability to access information online has been a big help.

I have no real likes or dislikes regarding the CARES program. (2 respondents)

In general, I find them to be quick and efficient.

I think that they have done a good job adjusting to the magnitude of calls that they receive, which I don't believe they originally anticipated. They have generally been timely in their callback response to us.

They have been incredibly responsive and very helpful. They always get back to us promptly. I have been pleased with the CARES line.

I believe it is positive in the sense that it is convenient: it gives us a central resource which we know we can contact.

We have had no real problems with the CARES line.

I find nothing to like about the CARES line. (5 respondents)

2) Would you describe what you dislike about the CARES line?

The CARES line was implemented without any thought. Often we receive different responses regarding whether or not we should have called the line based on who answers the phone. Specifically, we have been told that we do not need to call CARES, only to discover later (when payment is denied) that we did in fact need to call. It takes far too long for the SASS worker to arrive; I have had families waiting in the ER for up to six hours.

They often force you to hold for extended periods of time. Many of the line's workers are rude. They don't always follow through, nor do they always notify the hospital when they have failed to reach SASS. They have changed their procedures without notification in the past.

I don't like the fact that non-clinical people are making clinical decisions. Also, the workers are often rude.

We are often put on hold for a long time. Often CARES asks non-pertinent questions; the demand an entire medical history when it is unnecessary to do so. They are making a determination that they are often not qualified to make. They are at times rude. Honestly, I do not see the purpose of the CARES line. I believe that it is an unnecessary step. CARES should be more of an initial data collection service. There are currently too many levels present for justifying admission. The line is unfair when a family calls in and a non-master's level person is making the decision. Families may have difficulty appropriately describing their child to the CARES worker.

Sometimes the CARES workers seem very confused. They are inconsistent in the number of questions that they ask. It can take a long time to get ahold of them.

The time-frame for families in the ER has grown significantly. Our hospital is collecting data on this, and we have determined that the wait time has increased by at least one hour and up to three.

They are occasionally rude; when I call CARES it is because they have not been called in the ED, and the CARES line will at times criticize us for not calling when the patient was in the ED.

At first the program was difficult and confusing. There was more disagreement on individual cases, and there were some issues with expectations, etc. These issues seem to have been resolved, however.

We often let the parents speak to CARES when they are on the unit, and we find that CARES does really not understand the needs of this community. This is a small, rural town, and often parents don't have transportation, etc., so a referral to a SASS agency is simply not enough. CARES doesn't seem to have

anything else it can offer. Also, parents will get angry when CARES deflects their child. CARES is only interested in the answers to the questions they asked, but if the problem is more complex, they will not listen. At times we have had to ask for the supervisor because we did not trust the competence of the person with whom we initially spoke. I have no real likes or dislikes regarding the CARES program. I believe that the line is redundant when I have to call in for disposition and they have already spoken with the SASS worker regarding the patient. Also, they will at times deflect and refuse to reimburse if a patient is hospitalized, but then if the patient is not hospitalized they have no liability if that patient later harms himself or others. Also, it is very unclear what the qualifications of the CARES workers are, and I would prefer that they be trained mental health professionals.

There have occasionally been problems with them getting back to us in a timely fashion, particularly when something unusual has occurred and they have had to contact Springfield.

Sometimes, parents who speak directly to CARES do not understand why they do not meet the qualifications for admission under the acuity screen. It would be nice if CARES could find a way to better communicate with these parents.

There is no set time in which they are supposed to call SASS, and they give you know indication of exactly when they will call. I have waited up to 10 hours for a SASS worker to arrive, and in that case it was 2 hours before CARES even got in touch with SASS. If CARES would just be honest with me up front about how much time it was going to take them to call SASS, the system would run much more efficiently. As it happened in this case, the father missed a court date specifically because I told them that a SASS worker was on the way, and the SASS worker never arrived because he deemed the house “unsafe,” which was precisely why the child needed a SASS worker.

We have had a problem in the past because we have two provider numbers: one for the Children’s Hospital and one for the Medical Center. They have used the wrong number in the past, and it has forced us to spend some extra time. This is only a minor annoyance, though.

Things were shaky at first but seem to have improved.

I have no real dislikes.

3) Do you have any suggestions for the improvement of the CARES line?

I believe that the CARES line should be eliminated. We have board-certified professionals that are capable of doing what the CARES line does. We prefer being able to communicate with SASS directly. They must hire more people to answer the phones. Operators often put one on hold during a call in order to answer other calls.

CARES should be purely a message-taking service. It should be eliminated. CARES workers should not have to make decisions over the phone when they have not seen the families.

At times, we have communications issues with CARES staffers and have to ask for supervisors. The staffers will at times not understand what is being discussed and will not know how to begin the problem-solving process. This is to be expected, but can hopefully be resolved.

I like the idea of the line, but there needs to be more in place than just a 1-800 regional number. If possible, the program needs to be made more local. Communities like Chicago and our more rural community have extremely different needs, and the system needs to reflect this.

It is more convenient when someone picks up right away. It might be nice to have a few more people available to answer phones.

The clinician should be given a better idea of what to expect. There needs to be more concrete information given to the physician, and the system needs to be more efficient. Also, CARES needs to discuss with clinicians how to explain this whole process to the families. As mentioned previously, the lack of concrete information given by CARES regarding the timescale can have serious repercussions for the family.

I have no suggestions for the improvement of the CARES line.(9 respondents)

4) Would you describe what you like about the SASS program?

It is a good source for community referral and follow-through after admittance. It provides linkage for follow-up outpatient care.

They are knowledgeable and comprehensive.

They assist in finding other options for placement when patients cannot be admitted.

The evaluators seem very nice, very educated, and for the most part very respectful of the hospital staff's opinions.

They make a real effort to arrive in a timely fashion. There are usually there in 15-30 minutes, far exceeding their requirement. I also believe that it is less traumatic for a family when they have a SASS worker with them throughout the entire admission process. This aspect of the program may have reduced readmissions. SASS has also improved compliance with follow-up treatment.

We have a very good relationship with our local agency. Open communication exists between the hospital and the agency. We need people to go out into the homes after discharge, and we value the work that SASS does in this area. The program gives kids access to extra services that they might not otherwise have. They are given help with transportation to appointments, help with placement in residential programs, etc.

Our SASS workers are excellent. We have a very good relationship with them.

I think the program has the potential to be excellent. I have known some workers for years, and they are very good. It is excellent to have workers involved in discharge planning, and it is great that the parents get a chance to know their individual worker.

Our SASS provider, is excellent. They are always available, very caring, and usually arrive quickly. They are excellent.

When we need a SASS worker for a child on public aid, we can usually get one immediately. They are very involved with the patients.

I like that true mental health professionals do the screenings. We have an excellent SASS agency here, and I have no complaints about them.

Our SASS program is excellent, and we have a wonderful working relationship with them. They are very responsive, not only to our needs but also to the needs of outlying communities. We are the only hospital in a very large radius that handles child and adolescent psychiatric needs, so often our SASS agency must deal with more rural surrounding communities, and they do so very well. We had a meeting with our SASS agency early on when the changes were instituted to prepare us, and it was very successful, so much so that we have kept the meeting going on a quarterly basis.

I believe that many children are benefiting from the community-based program. The children do much better in their own environment than they would in a sterile office.

Some agencies do a very good job.

They usually arrive in about 50 minutes, which is a fair time window.

I have no particular likes regarding the SASS program. (2 respondents)

5) Would you describe what you dislike about the SASS program?

It often takes them an extremely long time to respond; families have had to wait up to 4-6 hours.

It often takes SASS workers far too long to arrive. Also, the workers often expect me to have done things which are not part of my responsibilities, e.g. set aside beds.

They are given 90 minutes to respond. As a result, emergency rooms become clogged. It takes far too long for the workers to arrive. At times, it has even taken several days.

When the SASS worker does not want to approve an admission, they are unwilling to compromise. They will try to deny admission over a doctor's recommendations.

We have some problems with documentation. At times, SASS workers will say that they have entered into the system that they were involved in discharge planning, but then public aid cannot find the entry. Also, both SASS and the hospital should not be required to contact H.S.I.; this is redundant. At the least, hospitals should be given a 24-hour window in which to call H.S.I., rather than the current 'same-day' window.

The current system provides an unnecessary double evaluation for children in an emergency setting. A double standard is in place for children with psychiatric illnesses. Children with, for example, asthma do not need to be screened multiple times, but under the current system children with psychiatric illnesses do. Also, there have been some communication issues with agencies out of our local area. Different agencies appear to set different standards. At times, we have had problems with agencies not contacting families after discharge, resulting in repeat hospitalizations. Some cases fall through the cracks. It seems like they have a difficult time holding onto staff.

I actually think that the DCFS SASS worked better than the current model. We have seen a real problem with follow-up. SASS workers are supposed to set up appointments to meet with families after a child is deflected. We do not see this happening in a timely fashion, and often the child just ends up back in the unit. Also, there are times when SASS workers refuse to go out to homes claiming that they are too dangerous, when we all know the family in question and know that this is not the case. SASS also claims that they will help families with transportation, but in this community, where transportation is a real problem, we don't see it happening.

If the child is not on public aid but could use a SASS worker, it is very difficult to get one.

There are a number of technical things of which we have to keep track: start times, stop times, when it is proper to request an extension, etc. This can be frustrating at times. Also, 90 days is a brief period of time, and sometimes it takes more than 3 or 4 days to contact a family. Many of the families are not easy to get in touch with. I would like to see a little more flexibility from the SASS program in this area.

I have dealt with SASS twice recently, and the first time, as mentioned earlier, I did not get a worker. The second time the worker seemed very rushed, and although he worked hard to secure a bed for the child, he didn't take a lot of time to explain the situation to the parents. He told them quickly what was happening on his way out. He needed to sit down with the patient and take some time or at least ask me to do so. He got the job done, but he did not seem very professional..

We have had problems with one agency in particular. They frequently fail to call us back, and we have had patients call to tell us that no one from SASS has called them or come out to the house. Also, they will call us to complain that we have not notified them of an admission when it is not our job to do that. Also, transfers take too long. Frankly, one of the two agencies with which we deal is incompetent. We often must take it upon ourselves to locate workers from the agency. They often fail to check the checkbox, which causes us to be denied payment. This is a major problem.

On 3 occasions, workers have disagreed with the hospital's disposition. Also, on rare instances, it has taken the workers 90 minutes to arrive, which is too long.

I find nothing to dislike about the SASS program. (4 respondents)

6) Do you have any suggestions for the improvement of the SASS program?

CARES needs to act as a facilitator of care, not a gatekeeper. They need to avoid immediately attempting to deflect cases and allow clinical people to do their jobs. SASS screeners need to collaborate more with caregivers. They must avoid immediate attempts at deflection, especially in crisis.

If possible, more workers should be hired and more centers should be opened. Currently, some centers must cover extremely large areas.

The program needs to hire more workers. Often there is only one worker on call for this location. SASS needs to hire more workers. Also, for people with Medicaid coverage, a call should not be necessary on top of evaluation in the ER; this is double work.

The program is important for follow-up but is not necessary in the ER; if we disagree with the SASS workers, we will always override their decisions.

The need for a second evaluation should be eliminated.

It seems that specific workers are often overwhelmed by their caseloads; they should try to strike a better balance between the workers.

Hospitals were simply presented with this program. If the program is revised, more hospital people should be involved in the development of the program.

The only suggestion I can make is that more workers should be hired.

I would like to see some increased flexibility regarding the time scale of SASS services and possibly even an extension of the 90-day length.

They should have more trained clinicians working for them.

First of all, they need to transfer cases as quickly as possible. The agency that receives the case needs to call us as quickly as possible to notify us of who the case worker is, what her number is, etc. Often we do not receive this information. We have blamed in the past for not calling when in fact we have called two or three times and the original case worker did not inform the case worker to whom the case was transferred. The agencies (one in particular with whom we work) need to take more responsibility and see there cases upon discharge. Often, as I said before, they are not following up after discharge as they should.

I have no suggestions. (7 respondents)

7) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the children and families you serve? If so, in what way?

Children and families have been negatively impacted by the delay in getting SASS workers on site. In addition, our hospital has a partial hospitalization program. The uninsured are now not eligible for this, although Medicaid patients are. A double standard has emerged.

SASS follows through more often, although still only about 80% of the time. Wait times for families has increased dramatically.

I believe that the children and families are better served since the changes were implemented.

They have slowed the process down. They have added an additional two hours to families wait times.

They have extended the time in the ER for some; however, there were fewer evaluators in the past, so the ER time has actually been decreased in some cases. Also, now with the increase in number of evaluators, there is better knowledge and better trust between SASS workers and the hospital.

They have increased the wait time for families in the ER. However, our hospital anticipated this, and we were prepared for it.

On the good side, we have seen better connection with families, particularly after discharge. On the bad side, ER waits have been lengthened considerably.

The changes have helped our families greatly, particularly from a financial perspective. It is just another hoop through which families have to jump. They have done a very poor job distributing information on the new program to the community (schools, law enforcement, etc.). Even this hospital just received brochures on the changes a few months ago.

There has been more conflict between SASS workers and parents. At times SASS attempts to deflect children that end up being admitted per parental request. SASS works very hard to keep children out of the hospital setting, and this can create conflict.

The changes have impacted those on public aid positively. They no longer have to go on waiting lists for services. The changes have decreased rehospitalizations for this group.

Yes -- the increased time length in the ER has made many 2nd shift admission move back to 3rd shift. First of all, this does require children and adolescents to stay up much later than is desirable. Also, 3rd shift was traditionally a time when the ER was relatively quiet, where patients were able to sleep, etc., and that has been compromised somewhat by the increased wait time. In the past we were able to assess patients within an hour; now it takes 3-4 hours to go through the entire process.

Some very needy families have been impacted in that they don't really understand the concept of the 90 days of service. They will think "oh, my child will be cured in 90 days." It is very difficult to explain that this is not the case to some low-functioning families. Again, we would prefer that the 90 days be extended.

I think they have impacted the families in a positive way. Now more people qualify for the 90 days of service, which is helpful with very few exceptions. The only problem is that some agencies do not follow up.

Yes: it has lengthened the average wait time by approximately 60-90 minutes.

The changes have had no impact. (2 respondents)

8) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the hospital's clinical operations? If so, in what way?

No: we still rely primarily on our physicians to decide whether or not admission is appropriate.

The hospital is often chaotic; the amount of time spent waiting on SASS only makes it more so.

At one point, we had a logistical problem with SASS pulling kids during group time. However, this was resolved with a simple phone call.

Clinical operations have actually improved to some degree. We can now better collaborate based on a child's current needs, and particularly his/her discharge planning needs. We are better able to have discussions with the SASS workers regarding an appropriate discharge plan. However, the changes have created an administrative nightmare. New bureaucratic steps have created a good deal of additional work, particularly the discharge-planning box. Issues with this box (whether or not it has been checked appropriately at each step in the process) have created at least 25-30% more work.

We are now more required to check on the patients benefits, etc. than we were in the past. In the past we were a little more lenient. Also, we are responsible for the SASS staffing now. Overall, I would say we are now more involved, which is certainly a good thing.

They have improved clinical operations regarding kids with whom we may have been on the fence. In the past, we might have admitted a kid even though we weren't convinced that he should be hospitalized just because other options were not available. Now, we know that the child will have access to SASS services. No, other than that our census is down.

They have tightened the hospital's connection to outpatient treatment. With the SASS worker present, follow-through is ensured when in the past it was not.

No, not really; the occasions where there have been disagreements between the hospital and CARES or SASS regarding admissions have been rare, and in those 3-5 cases the psychiatrist has overridden.

The reimbursement rate has been lower. Sometimes CARES will deflect against the wishes of our psychiatrist. Our psychiatrist will override the decision, but it will cause the hospital to lose money. This impact has been significant. Otherwise, the changes have simply created another hoop to jump through. It has affected the ER in that it takes up a room for an extra 90 minutes. Otherwise, there has been no effect on clinical operations.

The changes have had no effect on clinical operations. (6 respondents)

General Hospitals with Adolescent and Adult Inpatient Psychiatric Units

1) Would you describe what you like about the CARES line?

I have very little to say either for or against the CARES line.

I have no particular likes. (2 respondents)

2) Would you describe what you dislike about the CARES line?

At times I disagree with the CARES assessment; I would prefer if a SASS worker came out directly.

The line is at times very difficult to work with. Their screening criteria are not adequate. They ask very black or white questions that do not allow room for the many shades of grey into which these kids often fall. These questions should not determine a child's path of care.

My staff complains about having to deal with the CARES line at all. It prolongs times for patients in the ED, and it seems like an unnecessary extra step in the process. Also, at times my staff has reported that CARES workers seem confused about their roles.

3) Do you have any suggestions for the improvement of the CARES line?

The person making the decisions does not always have the ability to make the decisions. A SASS worker should come out regardless of the CARES assessment. An actually eyeballing of the patient is often necessary; it is difficult to properly describe a patient's condition over the phone.

They need to change their assessment criteria by widening them. In the ER, we have a very short amount of time with a patient, and we often don't have the time to do the sort of assessment needed to answer CARES' questions. It would be better if CARES spoke with the SASS worker after SASS had done the assessment.

I would suggest eliminating the line, taking the money used to fund it, and giving it to SASS agencies for more outpatient services. Resources should be diverted toward the back end of care.

4) Would you describe what you like about the SASS program?

I think that the SASS workers do very thorough assessments. They do a wonderful job.

The workers are nice and very easy to work with. They are excellent.

The program seems to work fairly well. The workers are timely, courteous, and responsive. We have not had any conflict with them. Their presence in the ED is helpful when we refer them to the agency in that the agency already knows the patient's name and situation. They are like a nice managed care company.

5) Would you describe what you dislike about the SASS program?

Their presence in the ED is just another overlay in the process. In my 4 years here, there has never been a case where the SASS worker has differed from our disposition; they just verify what we do.

There is nothing that I dislike about the SASS program. (2 respondents)

6) Do you have any suggestions for the improvement of the SASS program?

SASS needs to be more involved on the back end of care and less involved on the front end. It seems to me that lots of resources are being wasted. We have CARES, SASS, H.S.I. and us all watching the same case. Why is the state spending money on three levels of people? The system is no longer abusive but is monitored as if it were. The money used should be diverted so that patients can be linked up to care more quickly on the back end in order to reduce recidivism. Often it takes a long time for patients to gain access to outpatient services.

I have no suggestions. (2 respondents)

7) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the children and families you serve? If so, in what way?

They may have lengthened the time that the parent waits in the ER.

I think that they have helped both the kids and the parents. Many of these parents do not have the best parenting skills, and SASS has helped to ease that difficulty.

No, not really. No child has gotten better because of CARES.

8) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the hospital's clinical operations? If so, in what way?

They have helped us in our ability to deal with the kids that come in.

The ED has become more clogged, but otherwise no. If they were to disagree with our decision, we would override them. We would not put our liability in a state agency. But truly, we haven't had any differences of opinion.

The changes have had no effect on clinical operations.

General Hospitals with Adult Inpatient Psychiatric Units Only

1) Would you describe what you like about the CARES line?

The workers are always polite, kind, and helpful.

They always seem to answer promptly and are very nice.

The workers are generally very friendly and helpful.

There is nothing that I like about the CARES line. (6 respondents)

I have no real likes or dislikes regarding the CARES line.

2) Would you describe what you dislike about the CARES line?

It is unnecessary for people age 18-20. It is a lot of unnecessary extra work. The guidelines were not made clear on implementation; for example, there was no indication that CARES needed to be called upon discharge of a patient. Furthermore, they do not put information into the system in a timely manner.

When we were given training on the CARES line, we were told that they would have information on outpatient services to which we could refer patients even if they did not need hospitalization. They do not appear to have this information. We are also told to call if we have a patient age 18-20, but any such patient who has Medicaid still pending is rejected by the CARES line. I don't see the point of making the call in this case.

A few times I have been told that a patient does not meet the criteria for screening. This is fine, but then when I asked what the criteria were, they would not tell me; they just told me to call every time. I would like to have a better sense of this so that we don't waste time calling when a patient clearly fails to meet criteria.

There has been confusion about whether or not to call regarding patients between the ages of 18 and 21; we have been getting mixed messages.

We dread calling the CARES line because we know that, if we have to, the patient will be waiting here for 4-5 hours. In addition, at times we are on hold for up to 15 minutes.

I find it frustrating when we are told that a patient does not need to be seen when he/she is sitting in front of me and clearly needs to be seen. They ask a number of questions the answers to which are just repeated to the SASS worker. The process seems redundant. Also, I don't understand why people between 18 and 20 (legal adults) need to go through this process. The biggest problem has been the lag time between when we call CARES and when CARES calls SASS. This can take from 45 minutes to an hour. At times they will also call the wrong SASS agency; there is some confusion on the part of the CARES workers from time to time.

I have no particular dislikes regarding the CARES line.

I have no real likes or dislikes regarding the CARES line.

3) Do you have any suggestions for the improvement of the CARES line?

They need more available representatives.

I don't really see why our calls don't go directly to the local SASS agency; I don't really see the purpose of CARES.

They should probably employ more people; their workers seem to get really inundated and backlogged.

Again, I would just like to have a better sense of the criteria for screening.

It should not apply to anyone over 18. (2 respondents)

I have no suggestions. (4 respondents)

4) Would you describe what you like about the SASS program?

They provide good follow up, particularly for minors

In theory, I think that it is great to have kids assigned to a case worker. It should improve outpatient compliance.

The SASS workers are very good; I have no complaints about them.

The workers are good; I have no real complaints about the SASS program itself.

I have no particular likes or dislikes regarding the SASS program.

I find the SASS workers to be very capable, accepting, and easy to work with. They give very in-depth interviews to the patients.

I really believe in the SASS program.

I have no particular likes about the SASS program. (2 respondents) I like the program quite a bit; it is a good program to manage this age group. It also takes some of the pressure off of the intake department. I think it is an excellent idea.

5) Would you describe what you dislike about the SASS program?

I dislike that it applies to 18-20 year olds.

In practice, I am not seeing follow-up by SASS workers, particularly if a call is made and a patient is deflected. There also seems to be a great deal of confusion regarding whether it is the hospital's responsibility to contact the SASS worker or vice-versa after discharge.

At times the waiting period for their arrival is too long; it often takes over an hour, and there is frustration in the Emergency Department.

I have no particular likes or dislikes regarding the SASS program.

We don't always get a call back from the SASS worker after calling CARES, so we often don't have a sense of when the SASS worker will be arriving. This can be a problem with behavioral health patients, who tend to escalate.

From agency to agency, standards are different. There are definitely differences in response time and quality of care among different agencies.

We are no longer admitting 18-20-year-old patients because of the confusion with the SASS system; we have lost pay in the past over these patients.

There is nothing that I dislike about the SASS program. (2 respondents)

I believe that the program is redundant in the hospital. There is no need for a SASS evaluation in the ER when we have licensed, trained professionals on staff. It is a waste of everyone's time. Considering that we do not have a child and adolescent unit, we have no conflict of interest regarding SASS patients. I can see why such an evaluation might be necessary in a hospital with such a conflict of interest, and I can see how it would be useful for a hospital without licensed mental health professionals on staff, but in our case, it is redundant.

6) Do you have any suggestions for the improvement of the SASS program?

Eliminate it for the 18-20 age group.

In my experience, SASS has not always followed-through on their stated purpose. Kids are not receiving the services that they should be receiving. Regarding the wait times, their hands seemed to be tied; I'm not sure what else they can do. Perhaps they could train some more staff; at times the staff they send seems to be poorly trained, lengthening the wait times for the patients.

I think that, on their end, they have tons of paperwork that sometimes slows their response time.

There has been some confusion regarding what hospitals are responsible for regarding 18-21-year-old patients. Also, the Medicaid population often simply does not want the follow-up services; they simply want their children to be hospitalized.

I understood more about the new system after a seminar I attended, but these seminars are rare (I missed one and had to wait a month and a half before I could get into the next one). These seminars should be more frequent, particularly when there are changes in the system.

I have no suggestions. (3 respondents)

We should be able to do our own separate evaluation and then tell them what course of action we are taking. They should serve more like a managed care company, where we review the case for them over the phone and they decide whether or not to approve. Specifically, I believe that this should be the case for hospitals that have clinicians on staff but have no conflict of interest.

7) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the children and families you serve? If so, in what way?

Yes; I believe that adolescents are now being placed in more appropriate places.

The main impact has been on patients' wait times. Now, they are here for 3-4 hours longer than in the past. In the past, we could deal with each patient in about 30 minutes.

The level of care they receive has remained the same, but now they spend significantly more time (a couple of hours) waiting in the ER.

In the past, the system was more streamlined; the new system just adds another sometimes frustrating step for parents. On the other hand, children are getting follow-up services that they were not getting in the past, which is great.

No, most of the cases we have seen are 18-20-year-olds who are in ICS already. It seems useless to have this system in place for them.

On the positive side, we now have better access to getting kids into the hospital. SASS has a better sense than we do of what hospitals have available beds. On the negative side, wait times have increased for families, adding to their level of frustration. The sense that they must talk with multiple providers also adds to their level of frustration.

8) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the hospital's clinical operations? If so, in what way?

It has provided the hospital with more paperwork.

The main impact has been due to the increase in wait time. Now we often have to call someone down from the Psychiatry department just to baby-sit the patient.

Now we have to devote more resources to working within the system. Our case manager must spend more time making sure that there haven't been any glitches and that all relevant parties have been notified. This does take some time away from direct patient care.

The changes have had no effect on clinical operations. (3 respondents)

We have gone back and forth with the degree to which we need to be involved. It doesn't always make sense to do a full evaluation when another will be done by a SASS worker. If we are really busy, we might not do a full evaluation knowing that SASS will come in. The changes have affected our level of assessment and involvement.

General Hospitals with No Inpatient Psychiatry Unit

1) Would you describe what you like about the CARES line?

I have very little to say either for or against the CARES line.

I like the CARES line; I am personally not proficient in assessing children and adolescents, and I am glad to have CARES available as a resource.

They tend to respond quickly; our interactions with the CARES line have been mostly positive.

I have no particular likes.

2) Would you describe what you dislike about the CARES line?

At times I disagree with the CARES assessment; I would prefer if a SASS worker came out directly.

I don't have any particular dislikes about the CARES line.

There were some problems initially with getting them to call us back; we had to call them several times on occasion. There were also problems early with getting SASS workers here efficiently, but that seems to have improved.

It takes too long to get a worker to the hospital, but I don't know if that is on CARES' end or SASS' end.

3) Do you have any suggestions for the improvement of the CARES line?

The person making the decisions does not always have the ability to make the decisions. A SASS worker should come out regardless of the CARES assessment. An actually eyeballing of the patient is often necessary; it is difficult to properly describe a patient's condition over the phone.

They frequently assume that I am calling to request a SASS worker, when at times I may be calling to consult with CARES itself.

There needs to be greater consistency in their responses, that is in what circumstances they will accept a patient. I can call them and give the same information to two different people who answer the phone, and the decision may be different. We might call in one patient and have him rejected, and then call in an extremely similar patient a week later and have him accepted. Standards need to be more consistent.

I have no suggestions.

4) Would you describe what you like about the SASS program?

I think that the SASS workers do very thorough assessments. They do a wonderful job.

I am very satisfied with their timeliness.

I find that the SASS works well here; our local provider tends to be responsive.

I have no particular likes.

Generally, the workers are very competent and do their jobs well.

5) Would you describe what you dislike about the SASS program?

It takes them too long to get to the hospital. Also, they do a poor job keeping the nurses informed of what is going on with a given patient.

When we get a worker who is new to the program, the process becomes more cumbersome. The new workers often do not do everything that they are supposed to do, such as fully following through with the physicians.

I find nothing to dislike. (3 respondents)

6) Do you have any suggestions for the improvement of the SASS program?

There seems to be some confusion regarding what role the SASS workers take and what role the hospital takes; there needs to be better communication between the two so that everyone's role is clear.

The only real problem we have encountered is with the arranging of transportation. We do not have a psych unit, so any child that comes in must be transferred out, and there is often difficulty acquiring transportation.

They need to be more timely and to do a better job keeping staff informed.

No suggestions. (2 respondents)

7) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the children and families you serve? If so, in what way?

They may have lengthened the time that the parent waits in the ER.

Often, families come in insisting that their child be hospitalized, often against the best interests of the child. The changes have served to protect children from overzealous families. The changes have had no effect on the families and children we serve. (2 respondents)

8) Have the changes to the CARES and the SASS Program since July 1, 2004 impacted the hospital's clinical operations? If so, in what way?

The changes have had no effect on clinical operations. (4 respondents)

FY05 SASS Community Mental Health Provider Comments

August, 2005

** All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed. Missing numbers indicate surveys with no comments (or not returned). **

CMHP #05

SASS Increased collaboration and treatment planning with existing services as well as transitioning continuity of service important before & after SASS worker leaves (after 3 months). Agency finds it can be difficult for SASS worker to be reached for staffing on treatment planning for child to prevent Abrupt/frequent transitions for client during SASS intervention. Recommend SASS meet with any psychiatrist, counselor, etc. to provide comprehensive & effective services to help client experience less disruption and more continuity of care. Also, training in how to use CARES and SASS helpful to our agency in future (e.g., what CARES is, does as well as SASS).

* We have had minimal interaction with CARES and survey may reflect one to two interaction with SASS at most over the last 3 months *

CMHP #07

Often times the minors clearly demonstrate homicidal and/or suicidal behavior, but SASS staff have refused to approve hospitalization. On every occasion that we have been declined an appropriate disposition, we have gone to the psych hospital & a psychiatrist has agreed to hospitalization. It appears that SASS's criteria are higher than that of a psychiatrist.

CMHP #11

One provider for an entire LAN, who is uninterested in serving outlying counties, does not make sense. The quality and quantity of SASS services provided in our counties have decreased significantly.

CMHP #14

It has been a problem that SASS no longer provides crisis intervention services to families in the community who have private insurance.

Improve response time – calling CARES & then CARES calling SASS & then SASS responding takes significant time.

CMHP #15

Workers of CARES and SASS seem unclear of procedures – you can call with a problem and get conflicting information. Such as parents can or cannot directly call CARES. Also, SASS followup is sometimes too limited.

CMHP #18

Better follow up between family and SASS worker.

Improved communication between SASS worker and therapist.

CMHP #19

Don't include our agency in service plan. At times, our recommendations are not followed. No follow-up.

CMHP #21

It is disruptive to continuity of treatment when SASS becomes involved. We are not the SASS agent and if a child is hospitalized then getting approval to provide future treatment is difficult. Without approval the time that our crisis spent with youth is not billable and we lose Medicaid money. We should be allowed to bill for our time without getting the approval.

SASS provider is 50 miles from our agency. Travel time is hard to explain to parents when we have a crisis worker on staff.

Transportation to hospital – closest children's hospital is 2 1/2 hours away.

CMHP #22

Communication between SASS and [this provider]'s clinicians about open clients needs to take place in a timely and expedient fashion. It is imperative that the outpatient service provider be included in the Aftercare Planning prior to discharge via the SASS caseworker/therapist.

CMHP #23

We have not received any payment for SASS services rendered for the entire past fiscal year. This has seriously hindered our services. With no funding, it makes services very difficult to provide, especially since SASS services are to be provided in the community. This means extra financial burden of transportation and this also ties the SASS worker up in time management. Our SASS screenings are provided by another agency. We have a good working relationship with their agency. This has not been a problem.

CMHP #25

Suggestions to improve

1. Hire master level SASS workers – 40 hours of crisis training is not efficient.
2. Staff know the client, their history and home environment – SASS worker needs to listen to staff – not just the client, as most kids are resistant to being hospitalized.
3. SASS worker needs to provide follow-up information – plan? – with the client's therapist.
4. SASS worker needs to be more concerned about child/adolescent than discussing # of hospitalizations so they (their agency) looks good on paper.
5. Duplication of services – (2 billings for crisis intervention)
6. Children and adolescents have informed therapists that they will not talk to a "Stranger" about their problems.

Problems [unclear] clt's at risk of being hurt or dying

1. One clt was assessed by therapist & supervisor – SASS called. Clt reported he was suicidal & had a hx of overdosing. Clt was deflected by SASS. Overdosed the next day.
2. Clt threatened to run out in the traffic. Six police cars & paddy wagon involved to take clt to ER for SASS eval. Clt deflected – 3 days later attempted to run into traffic when at a social event.

My staff provided input for this survey: SASS worker [name] at [SASS provider name] is a role model for an excellent SASS worker.

CMHP #32

These responses reflect those of the crisis clinicians for the SASS program only. Not on-going services.

CMHP #33

Our agency provides service to a lot of adult ACT clients who may be under DCFS from age 18-21 years. When we have to certify a client for involuntary admission to the hospital, it is usually an urgent situation. The involvement of SASS with these adult clients makes it difficult for us to keep all of our clients safe and to manage clinical emergencies effectively, due to delay in SASS response time. These issues were raised at several SASS trainings/information meetings with DMH/ SASS staff.

CMHP #34

[unclear] Contracts be allowed to be split among LANS.

CMHP #38

Our agency has not used the CARES line in the past 3 months.

CMHP #41

We served as SASS provider for our county quite effectively prior to the restructuring. We do not provide SASS services since the contracts went to one agency per LAN.

I see some losses in the following areas:

1. lack of awareness of community resources as new SASS agents are not rooted in the community.
2. loss in continuity of care in losing clients to SASS agent during a difficult time.
3. loss of family involvement due to new providers lack of rapport.

CMHP #45

We provide the followup services to SASS clients. Cares often doesn't notify us of SASS approved clients and their period of eligibility.

CMHP #51

Please consider improvements to the process of authorizing a child to receive out-patient services from an agency once employed in SASS. Currently to serve a SASS child we must

- 1) Know the child is a SASS recipient.
- 2) Notify our local SASS provider that we've received a SASS child's referral.
- 3) Wait for provider to get CARES to approve case for O.P. therapy.
- 4) Do a manual billing form post services.
- 5) Wait for IDPA to send permission to submit bill for payment (letter).

A bit cumbersome

CMHP #54

SASS Services Comments

1. The length of time from crisis to disposition can be up to 6 hours. This is unacceptable. The ED turnaround needs to be 1-2 hours at the most.
2. Information has to be given twice in the ED. Once to the CARES line and then again when SASS arrives. This is time consuming for the ED staff.
3. Process into the system needs to be streamlined. The intake assessment is done at a different time than the SASS assessment. Couldn't they be done at the same time?

3. CARES line should not put people on hold. Computer problems are frequent and they say they will call back with the entry number and then don't. They say the last shift did not pass on the info to call. Back. Communication needs to be improved.

CMHP #57

The CARES system adds a layer of bureaucracy to the system and delays care during a time of crisis.

CMHP #58

The time it takes for SASS to arrive after the initial call is a huge problem. It is always at least 1 hour. Sometimes, it is 2 to 3 hours. Many times they do not see or talk w/the child. No plan is ever developed to prevent re-occurrence.

There seems to be a lack of communication between SASS and hospitals. The wait at the hospitals is outrageous. There is no aftercare or services provided post hospitalization.

They are generally very nice people when they come out.

* They also seem scared with more aggressive clients.

CMHP #59

We have experienced a lot of inconsistency in the response from hospital programs in our area. [Hospital name] has been excellent. Others have been ok to poor. There has been some improvement in the last 6 months.

There is a major gap in resources available to children who have Medicaid and those who are unfunded. Medicaid clients have more resources available to them, such as ambulance services and IOP services.

CMHP #63

The Cares line workers should not be giving the "Acuity Tests." Professionals who have had a history of working with the client are more capable of deciding who needs to be hospitalized.

CMHP #65

II. Suggestions for Improvement

- 1) increase # of staff
- 2) Hire persons with more education and experience
- 3) Incorporate more case management & transition services into regular programming

III. State level problem/CARES

- 1) SASS listed as Provider Program 120 providing services and not getting paid

IV. Working well

- 1) Immediate assessment
- 2) Availability of flex funds for Program 120 kids, ICG kids
- 3) Coordination of ICG kids/respite